S. HRG. 99-799

EXAMINATION OF RURAL HOSPITALS UNDER THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

MAY 9, 1986

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EXAMINATION OF RURAL HOSPITALS UNDER THE MEDICARE PROGRAM

FRIDAY, MAY 9, 1986

U.S. SENATE,
COMMITTEE ON FINANCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room SD-125, Dirksen Senate Office Building, the Honorable David Durenberger (chairman) presiding.

Present: Senators Durenberger, Dole, Heinz, Baucus, and Mitchell.

[The press release announcing the hearing, the prepared written statements of Senators Dole and Baucus and a background paper follow:]

[Press Release No. 86-024, Apr. 7, 1986]

FINANCE COMMITTEE SUBCOMMITTEE ON HEALTH TO EXAMINE RURAL HOSPITALS UNDER THE MEDICARE PROGRAM

The condition of rural hospitals under the Medicare program will be examined at a Committee on Finance's Subcommittee on Health hearing scheduled for May 9, 1986, Chairman Bob Packwood (R-Oregon) said today.

Senator Packwood said the hearing would begin at 9:30 a.m., Friday, May 9, 1986, in Room SD-215 of the Dirksen Senate Office Building in Washington, D.C.

Senator Packwood said Senator David Durenberger (R-Minnesota), Chairman of the Subcommittee on Health, would preside at the May 9 hearing.

Hospitals were given incentives to provide quality health care at lower costs when Congress enacted the Medicare Prospective Payment System (PPS) in 1983, said Senator Packwood. The time has come to examine the impact of PPS on the stability of small, rural hospitals and consider whether access to quality health care in rural communities is being preserved. In addition to any effects PPS may have had an rural hospitals, the Committee is interested in knowing what effect other program elements (such as the swing bed, sole community providers and rural referral center provisions) have had on rural hospitals.

Chairman Packwood said the Subcommittee on Health expects to receive testimony from the Department of Health and Human Services, as well as representatives from the hospital industry, rural health care providers and others.

STATEMENT OF SENATOR BOB DOLE
HEARING ON RURAL HOSPITALS
MAY 9, 1986

MR. CHAIRMAN, I WISH TO COMPLIMENT YOU FOR HOLDING THIS HEARING AND FOR BRINGING OUR CONCERN FOR RURAL HOSPITALS TO THE FORE. FIRST OF ALL, WHEN WE ENACTED THE MEDICARE PROSPECTIVE PAYMENT SYSTEM IN 1983, WE KNEW HOW IMPORTANT ONGOING MONITORING, EVALUATION, AND FINE-TUNING WOULD BE -- THAT'S WHY WE ASKED FOR THE STUDY OF THE URBAN/RURAL PAYMENT DIFFERENTIAL. WE KNEW THAT RURAL HOSPITALS NEED PARTICULAR ATTENTION. IN PAST LEGISLATION, WE CREATED THE SWING BED PROGRAM, SPECIAL PAYMENTS FOR SOLE COMMUNITY PROVIDERS AND REGIONAL REFERRAL CENTERS AND, IN OUR MOST RECENT RECONCILIATION BILL, WE ESTABLISHED THE DISPROPORTIONATE SHARE ADJUSTMENT WHICH PROVIDES AN ADDED PAYMENT TO THOSE HOSPITALS, BE THEY URBAN OR RURAL, SERVING AN UNUSUALLY LARGE NUMBER OF POOR ELDERLY.

THESE EFFORTS WERE MEANT TO PROTECT THESE VALUED RESOURCES TO OUR RURAL ELDERLY, BUT THEY MAY NOT BE ENOUGH. IN ORDER TO DETERMINE WHAT ADDITIONAL ASSISTANCE MIGHT BE NECESSARY, WE NEED GOOD, SOLID INFORMATION. I HOPE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES WILL GIVE US THE RESULTS OF THE STUDIES SO THEY CAN BE OF USE TO US AS WE SEEK ANSWERS TO TODAY'S PROBLEMS. BUT

I SUPPOSE WE ARE GOING TO BE HEARING ABOUT STUDIES IN PROGRESS, NOT THE RESULTS WE NEED. QUITE FRANKLY, IT IS A BIT PERPLEXING WHEN, ON THE ONE HAND, THE ADMINISTRATION GOES ON RECORD WITH A COMMITMENT TO INSURE APPROPRIATE AND EQUITABLE PAYMENTS TO RURAL HOSPITALS AND THEN, ON THE OTHER HAND, FAILS TO EVEN ACKNOWLEDGE THE OVERDUE URBAN/RURAL PAYMENT DIFFERENTIAL STUDY.

HOWEVER, I AM GRATIFIED TO SEE THE OUTSTANDING PANEL OF WITNESSES WE HAVE WITH US TODAY. OF COURSE, I TAKE EXCEPTIONAL PLEASURE IN WELCOMING MR. CURTIS C. ERICKSON, WHO HOLDS THE DOUBLE DISTINCTION OF BEING THE PRESIDENT AND CHIEF EXECUTIVE OFFICER OF THE GREAT PLAINS HEALTH ALLIANCE, PHILLIPSBURG, KANSAS, AND WHO IS ALSO A NEWLY APPOINTED COMMISSIONER OF THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION REPRESENTING RURAL HOSPITALS. I AM PLEASED THAT WE WILL DERIVE THE BENEFIT OF YOUR INSIGHT AND EXPERIENCE, AND I KNOW THAT YOUR CONTRIBUTION TO THIS HEARING AND TO THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION WILL BE MOST VALUABLE. YOU HAVE ALREADY PROVEN YOURSELF TO BE A GREAT RESOURCE TO KANSAS, ESPECIALLY TO OUR RURAL CITIZENS. THANK YOU FOR COMING TODAY. AND MY THANKS TO MR. DON WILSON, THE EXECUTIVE DIRECTOR OF THE KANSAS HOSPITAL ASSOCIATION FOR HIS SUPPORT AND ASSISTANCE AS WELL.

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Statement by
Senator Max Baucus
on the
Impact of Medicare Prospective Payments on Small Rural Hospitals

May 9, 1986

Mr. Chairman, small rural hospitals are on the critical list. And their vital life signs are weakening.

According to the report prepared by the Congressional Research Service for today's hearing, 80 percent of the hospitals that closed last year were small, and most were located in rural communities.

In the future, the hospitals that are most likely to close are small and rural.

Right now, nearly 70 percent of the rural hospitals with under 50 beds are unable to cover their costs with revenues from patients.

When these hospitals have losses, they have to turn to their communities for help. But many of these same communities are also struggling to survive. They may not be able to bail out these hospitals much longer.

Without small rural hospitals, patient care suffers. The communities suffer by lost employment and new residents and businesses have no reason to move to town. And Medicare suffers, too, if patients are forced to seek care in more distant, and more costly urban centers.

And in some cases, especially in states like Montana, there may be no other hospital nearby to take their place.

When we started down the prospective payment path, we all knew that some hospitals would close.

The critical question is what happens when the "wrong hospital" closes? The remote hospital that serves an entire region -- the hospital that is critical to basic access to care for the entire population? What happens to the elderly who are the highest users of health care, who disproportionately live in rural America, who are less mobile, and whose health care needs are more acute and immediate?

The sad fact is that we don't have an answer to that question right now.

Competition won't solve that problem. Well-meaning rhetoric won't help either.

It's time to decide now how we are going to face that situation. Before it is too late for rural America.

Earlier this week, I and Senator Grassley introduced the Rural Health Care Improvement Act. This legislation has two objectives:

First, it would require HHS to pay more attention to rural health care concerns by:

o requiring a rural impact test on Medicare and Medicaid regulations before they are issued.

o mandating that 10 percent of research funds be used to explore rural health issues.

o establishing a rural health policy office within HCFA.

Second, it would provide for fairer payments to small rural hospitals by:

o paying Medicare bills on time.

o paying small hospitals a fair amount for extremely high cost, "outlier" cases.

o maintaining predictable, stable payments for capital expenses of sole community provider hospitals.

We think that this legislation is a solid first step. It's not a guarantee that rural hospitals won't close. But it brings them more into the central debate going on in this town about the future of health care.

It's high time that Washington started to pay attention to these needs.

I hope that today's witnesses will let us know if the bill can be improved. If other measures are needed.

I also hope to hear whether today's witness believe that all small rural hospitals belong on PPS in the first place. Or whether the sole community provider program is working as planned.

Together we can work to ensure that access to quality health care is a reality for all Americans.

RURAL HOSPITALS AND MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

Background Paper

Prepared for the Use of the Members of
the Committee on Finance

May 1986

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RURAL HOSPITALS AND MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

INTRODUCTION

This background paper presents some of the major issues which have been raised about rural hospitals, particularly those issues related to Medicare's system for hospital payment, known as the Prospective Payment System (PPS). The prospectively-determined, fixed PPS payment rates have had a significant impact on certain hospitals, particularly hospitals such as rural hospitals which tend to have large Medicare patient loads. It should be kept in mind, however, that many rural hospital problems predate the implementation of PPS, which began in October 1983.

This paper is presented in five sections. Section I provides some general information on characteristics of rural hospitals. Section II discusses features of PPS which impact on rural hospitals. Section III presents other rural hospital issues, particularly those related to the financial problems of rural hospitals and the impact of rural hospitals on their communities. Section IV describes certain efforts undertaken by rural hospitals to help address some of these problems. Section V summarizes rural hospital legislation related to the Medicare program.

Rural areas of the United States have their own unique characteristics which set them apart from urban areas. These characteristics include "low population density, . . . distance from urban resources, the relative predominance of an unperturbed natural ecology, and the small sizes of the involved communities."1/ There is no consensus about how to define a rural area. A number of approaches have been used, generally using population size on which to base a demographic classification system.

This background paper uses the terms "rural and urban" as they are defined by the Medicare program; i.e., based on the geographic classification system known as Metropolitan Statistical Areas, or MSAs. This system, which is maintained by the federal Office of Management and Budget, defines an MSA (or urban area) as a city or urbanized area of at least 50,000 population, with a total metropolitan population of at least 100,000. MSAs are defined as entire counties, except in New England where they are defined in terms of cities and towns. In addition to the county containing the main city, an MSA also can include additional counties having economic and social ties to the central county. Rural areas are those not located within MSAs.

Hospitals located in rural areas have characteristics which generally set them apart from hospitals in nonrural areas. They are smaller, have fewer personnel and specialized services, lower occupancy rates, and serve a population more likely to be uninsured or under-insured as well as older than average. Rural hospitals are more likely to be owned by local governments and are generally less costly to operate than urban hospitals. The rural hospital also is more likely to be the focal point for the health care provided within a large geographic area.

Recently, considerable attention has been devoted to the perceived problems of rural hospitals. Rural hospitals, like other hospitals, are being

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1/ Rosenblatt, Roger A., and Ira S. Moscovice. Rural Health Care. New York, John Wiley & Sons, Inc. 1982. p.9.

affected by changes in the U.S. health care system, such as the efforts to reduce health care costs, changes in hospital reimbursement systems, and increasing competition from other hospitals and other types of providers. These changes have resulted in fewer hospital admissions, declining lengths of stay, and increasing severity of illness of the patients who are admitted to hospitals. Although these changes pose problems for all hospitals, some experts believe rural hospitals are affected more severely because their financial situation is more precarious than that of urban hospitals; for example, their costs must be spread over a smaller number of patients, or they may be just breaking even in terms of their costs compared to revenues, leaving little leeway for adverse financial changes.

I. GENERAL INFORMATION ON RURAL HOSPITALS

A. Distribution

Almost half of all community hospitals 2/ are rural, outside of Metropolitan Statistical Areas. According to 1984 data from the American Hospital Association (AHA), of the 5,759 community hospitals in the United States, 47 percent (2,696) were located in rural areas and 53 percent (3,063) were located in urban areas (see table 1). This proportion varies by region. For example, in the West North Central region, 75 percent of community hospitals were rural; in the Middle Atlantic region, 18 percent of hospitals were rural.

Unless otherwise noted, hospital data in this paper are limited to community hospital data.

2/ The American Hospital Association defines community hospitals as all nonfederal short-term general and other special hospitals (excluding hospital units of institutions) whose facilities and services are available to the public.

TABLE 1. Hospital Distribution by Location and Region, 1984

	Number of hospitals	Percent of total		Number of hospitals	Percent of total
			Census Division 5,		
United States	5,759	100.0%	East South Central	491	100.0%
Rural	2,696	46.8%	Rural	314	64.0%
Urban	3,063	53.2%	Urban	177	36.0%
Census Division 1,			Census Division 6,		
New England	249	100.0%	West North Central	792	100.0%
Rural	85	34.1%	Rural	595	75.1%
Urban	164	65.9%	Urban	197	24.9%
Census Division 2,			Census Division 7,		
Middle Atlantic	603	100.0%	West South Central	842	100.0%
Rural	107	17.7%	Rural	453	53.8%
Urban	496	82.3%	Urban	389	46.2%
Census Division 3,			Census Division 8,		
South Atlantic	823	100.0%	Mountain	371	100.0%
Rural	353	42.9%	Rural	261	70.4%
Urban	470	57.1%	Urban	110	29.6%
Census Division 4,			Census Division 9,		
East North Central	888	100.0%	Pacific	700	100.0%
Rural	362	40.8%	Rural	166	23.7%
Urban	526	59.2%	Urban	534	76.3%

SOURCE: American Hospital Association, Hospital Statistics, 1985 Edition. Data from the American Hospital Association 1984 Annual Survey.

B. Bed Size

Of the 1 million hospital beds in the U.S., 23 percent (230,000) were rural beds and 77 percent (780,000) were urban beds, according to the 1984 AHA data (see table 2).

On average, rural hospitals were about one-third as large as their urban counterparts. The average rural hospital had 86 beds; the average urban hospital had 256 beds. The distribution by bed size is shown in table 2. In 1984, 71 percent of all rural hospitals had fewer than 100 beds while 23 percent of all urban hospitals had fewer than 100 beds.

State-by-State information on the percentage of hospitals and the percentage of beds located in rural areas can be found in the Appendix, Item A.

TABLE 2. Bed Size by Location, 1984

	United States	Rural	Urban
Number of beds	1,017,057	232,746	784,311
(Percent of U.S. total)	100.0	22.9	77.1
Average bed size	177	86	256
Bed size distribution			
6-24 beds	215	182	33
25-49 beds	987	799	188
50-99 beds	1,408	932	476
100-199 beds	1,378	606	772
200-299 beds	734	131	603
300-399 beds	436	34	402
400-499 beds	269	6	263
500 or more beds	332	6	326

SOURCE: Number of Beds--American Hospital Association, Hospital Statistics, 1985 Edition. Data from the American Hospital Association 1984 Annual Survey. Bed Size Distribution--American Hospital Association, Unpublished data from the American Hospital Association 1984 Annual Survey.

C. Utilization

In 1984, rural hospitals accepted 21 percent (7 million) of the nation's 35 million admissions for inpatient services (see table 3). Urban hospitals admitted 79 percent (28 million) patients.

Statistics on average daily hospital census (the average number of patients receiving care each day) show a similar pattern. The average daily census in rural hospitals accounted for 20 percent of the total daily census for all hospitals (141,000), while the average for urban hospitals was 80 percent (560,000). The per day census average for the entire U.S. was 702,000.

The occupancy rate for rural hospitals was therefore almost 11 percent lower than the urban rate in 1984. The occupancy rate is defined as the ratio of the average daily census to the average number of beds. Rural hospitals on average filled 61 percent of their beds; urban hospitals filled 72 percent. The national average occupancy rate was 69 percent.

Rural hospitals provided roughly one-sixth of all surgical operations and one-fifth of all births in 1984. Of the almost 20 million surgical operations, rural hospitals provided 17 percent (3 million) and urban hospitals provided 83 percent (16 million). The number of infants born in U.S. community hospitals was 3.5 million. Rural hospitals accounted for 19 percent (670,000) of these births, urban hospitals for 81 percent (3 million).

TABLE 3. Utilization by Location, 1984

	United States	Rural	Urban
Admissions	35,155,462	7,449,696	27,705,766
(Percent of U.S. total)	100.0	21.2	78.8
Average Daily Census	701,687	141,272	560,415
(Percent of U.S. total)	100.0	20.1	79.9
Occupancy (Percent)	69.0	60.7	71.5
Surgical Operations	19,908,241	3,382,278	16,525,963
(Percent of U.S. total)	100.0	17.0	83.0
Births	3,456,308	671,225	2,785,083
(Percent of U.S. total)	100.0	19.4	80.6

SOURCE: American Hospital Association, Hospital Statistics, 1985 Edition. Data from the American Hospital Association 1984 Annual Survey.

D. Occupancy Trends

In recent years, the average occupancy rate for all hospitals has declined from 76 percent in 1980 to 69 in 1984 (see table 4). Rural hospitals have experienced a larger decline in occupancy, falling from 69 percent in 1980 to 61 percent in 1984. Urban hospital occupancy fell from 78 percent in 1980 to 72 percent in 1984.

The largest annual decline in occupancy percentages occurred between 1983 and 1984. The average U.S. hospital experienced a -6 percent change. The occupancy rate of rural hospitals decreased more severely, with a -8 percent change. Urban hospitals faced a -6 percent change.

TABLE 4. Occupancy Rates by Location, 1980-1984

	United States	Rural	Urban
Occupancy (Percent)			
1980	75.6	68.6	77.9
1981	76.0	68.6	78.4
1982	75.3	67.9	77.6
1983	73.5	66.1	75.8
1984	69.0	60.7	71.5
Percent change 1983-1984	-6.1	-8.2	-5.7

SOURCE: American Hospital Association, Hospital Statistics, 1985 Edition. Data from the American Hospital Association 1984 Annual Survey.

E. Medicare and Medicaid Volume

In 1984, rural hospitals had a larger proportion of Medicare discharges per total admissions than did urban hospitals. Rural hospitals discharged 3 million Medicare patients and had 7 million total inpatients admissions, for a 37 percent proportion of Medicare discharges to total admissions. (see table 5). Urban hospitals discharged 9 million Medicare patients and had 27 million total inpatient admissions, for a 31 percent proportion.

Medicaid discharges represented about 10 percent of total inpatient admissions for both rural and urban hospitals.

TABLE 5. Medicare and Medicaid Volume by Location, 1984

	United States	Rural	Urban
Medicare Discharges	11,461,554	2,781,709	8,679,845
(Percent of total admissions)a/	32.6	37.3	31.3
Medicaid Discharges	3,623,594	734,550	2,889,044
(Percent of total admissions)b/	10.3	9.9	10.4
Total Admissions	35,155,462	7,449,696	27,705,766
(Percent of total admissions)	100.0	100.0	100.0

a/ Proportion of Medicare discharges to total inpatient admissions.
b/ Proportion of Medicaid discharges to total inpatient admissions.

SOURCE: Medicare Discharges and Medicaid Discharges--American Hospital Association, Unpublished data from the American Hospital Association 1984 Annual Survey. Total Admissions--American Hospital Association, Hospital Statistics, 1985 Edition. Data from the American Hospital Association 1984 Annual Survey.

F. Expense Trends

On the average, treating patients in a rural hospital is less costly than in an urban hospital, according to AHA data. In 1984, the average expense for a rural admission was $1,962 (see table 6). The average expense for an urban admission was $3,277. The national average expense per admission was $2,995. Per inpatient day, the average expense for a rural hospital was $284, and for an urban hospital was $443. The national average per inpatient day was $411.

TABLE 6. Expenses by Location, 1980-1984

	United States	Rural	Urban
Total Expenses (in thousands)			
1980	$ 76,851,146	$12,745,540	$ 64,105,606
1981	90,572,422	13,647,817	76,924,605
1982	104,875,624	15,810,304	89,065,320
1983	116,437,675	16,727,108	99,710,567
1984	123,336,420	17,277,571	106,058,849
Percent of U.S. total, 1984	100.0	14.0	86.0
Adjusted Expenses, Per Admission a/			
1980	$1,850.96	$1,223.41	$2,061.17
1981	2,171.20	1,418.67	2,396.77
1982	2,500.52	1,649.43	2,752.65
1983	2,789.18	1,834.87	3,055.80
1984	2,995.38	1,961.92	3,276.55
Adjusted Expenses, Per Inpatient Day a/			
1980	$245.12	$176.72	$265.56
1981	284.33	199.11	307.69
1982	327.37	228.95	354.42
1983	369.49	255.65	399.33
1984	411.10	283.88	443.47

a/ Derived by subtracting outpatient expenses from total expenses. This number, representing inpatient expenses, is divided by total admissions to derive the average expense per hospital stay.

SOURCE: American Hospital Association, Hospital Statistics, 1981-1985 Editions. Data from the American Hospital Association 1980-1984 Annual Surveys.

G. Profitability

Data from the Healthcare Financial Management Association's (HFMA) Financial Analysis Service show that, despite recent increases in operating margins for all hospitals, rural hospitals still have lower operating margins relative to urban hospitals. The operating margin ratio is a measure of profitability--the excess of revenues over expenses. The ratio is defined by the HFMA as the proportion of operating revenue retained as income (i.e., the difference of total operating revenue minus total expenses, all divided by total operating revenue). The median operating margin for rural hospitals rose from 1.7 percent in 1980 to 2.3 percent in 1984 (see table 7). The median operating margin for urban hospitals rose from 2.1 percent in 1980 to 3.3 percent in 1984. Overall, the national median operating margin rose from 1.9 percent in 1980 to 3.1 percent in 1984.

TABLE 7. Operating Margin Ratio by Location, 1984

	United States	Rural	Urban
Operating Margin Ratio a/			
1980	.019	.017	.021
1981	.020	.014	.021
1982	.020	.014	.021
1983	.023	.016	.026
1984	.031	.023	.033

a/ (Total operating revenue - operating expenses) / total operating revenue.

SOURCE: Healthcare Financial Management Association's Financial Analysis Service as reported in Prospective Payment Assessment Commission, Medicare Prospective Payment System: Report to the Congress, February 1986.

H. Hospital Closings

Of the 49 community hospital closings in 1985, 21 occurred in rural areas and 28 occurred in urban areas (see table 8). Three rural specialty hospitals closed and nine urban speciality hospitals closed, for a total of 12 specialty hospital closings.

TABLE 8. Hospital Closings by Location, 1985

	United States	Rural	Urban
Community Hospitals	49	21	28
Specialty Hospitals	12	3	9

SOURCE: American Hospital Association, as reported in Hospitals, April 5, 1986, p. 93.

II. THE PROSPECTIVE PAYMENT SYSTEM AND RURAL HOSPITAL ISSUES

A. Background

Medicare payments for inpatient hospital care are made according to the Prospective Payment System (PPS). PPS was authorized by P.L. 98-21, the Social Security Amendments of 1983 (April 20, 1983), and became effective for hospital cost reporting periods that began on or after October 1, 1983. Under PPS, Medicare-eligible hospital inpatients are classified into one of 468 diagnosis related groups (DRGs) based on their diagnosis, and the hospital is paid a predetermined rate based on the patient's DRG classification. A number of PPS features, described below, have been identified as having an impact on rural hospitals, including the urban/rural DRG payment differential, the wage index adjustment, payments for outlier cases, and special payment provisions for sole community providers, referral centers, and hospitals serving a disproportionate share of poor patients.

B. The Urban/Rural Payment Differential

P.L. 98-21 provided that different PPS payment rates would apply to hospitals located in urban and rural areas of the country. The law defines an urban area as "an area within a Standard Metropolitan Statistical Area (as defined by the Office of Management and Budget) or within such similar area as the Secretary has recognized . . . by regulation; and the term `rural area´ means any area outside such an area or similar area." P.L. 98-21 required the Secretary of Health and Human Services (HHS) to study and report to Congress by the end of 1985 on the feasibility and impact of eliminating or phasing out separate urban and rural PPS rates; this study (including a number of other urban/rural issues) is in progress and has not yet been submitted to Congress.

In October 1983, when PPS was first implemented, the Department of Health and Human Services (HHS) chose to use the Office of Management and Budget´s Metropolitan Statistical Area (MSA) designations (which replaced the Standard Metropolitan Statistical Area designations in June 1983) in determining whether a hospital is classified as urban or rural. HHS indicated at the time (in regulations issued Jan. 3, 1984) that the MSA system was "the only one that meets the requirements for use as a classification system in a national payment program."

Separate urban and rural PPS rates were calculated by updating urban and rural hospital data from a base pre-PPS period. Since on average the base rural hospital costs were lower than the urban hospital costs, the standardized PPS payment amounts calculated each year since October 1, 1983 have been lower for rural hospitals than for urban hospitals. These cost differences exist even after adjustments have been made for teaching activity, area wage differences, and DRG case mix. For example, the Fiscal Year 1985 national standardized PPS payment amount per case was 20 percent (or approximately $600) lower for rural hospitals than for urban hospitals. During the transition period (Fiscal Years 1984-1987) when the PPS rates are composed of a blend of regional and national DRG rates, the difference between the rural and the urban standardized payment amounts can vary even more by region. (See the Appendix, Item B, for a map showing States by region.) For Fiscal Year 1985, the smallest difference was for the Middle Atlantic region (PA, NJ, and NY) where the rural amount was 9 percent lower than the urban amount; the largest difference was in the West North Central region (IA, KS, MN, MO, NB, ND, and SD) where the rural amount was 23 percent lower than the urban amount.

As the Prospective Payment Assessment Commission (ProPAC) described in its April 1, 1986 report to Congress,[3] the method used by HHS to calculate the PPS standardized payment amounts has also contributed to the differences in payment between urban and rural hospitals. The standardized payment amounts were developed by calculating the average cost per discharge for each hospital, adding them together for all hospitals, and then dividing by the number of hospitals. This approach does not take the hospital's number of Medicare discharges into account, but instead gives each hospital an equal weight.

ProPAC suggests that the standardized amounts also could have been calculated by weighting the calculation by the number of discharges; i.e., to multiply each hospital's cost per case by its total Medicare discharges, to add them together for all hospitals, and then to divide by the total number of Medicare discharges. ProPAC's analysis [4] indicates that using the discharge-weighted method instead of the current hospital-weighted method would remove about $90 (15 percent) of the $600 difference between the Fiscal Year 1985 urban and rural standardized amounts. Using discharge-weighting to calculate the Fiscal Year 1985 national standardized amounts would have raised the rural amount by 3.1 percent and lowered the urban amount by 0.5 percent. The differences are even greater if looked at by region. For example, the rural standardized amount for the West North Central region would be 6.3 percent higher using discharge weighting; the urban standardized amount for the South Atlantic region (DE, DC, FL, GA, MD, NC, SC, VA, WV) would be 1.8 percent lower.

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[3] Prospective Payment Assessment Commission. Technical Appendixes to the Report and Recommendations to the Secretary, U.S. Department of Health and Human Services, April 1, 1986. Washington, U.S. Govt. Print. Off., 1986. pp.32-34.

[4] Ibid., p.33.

Although P.L. 98-21 provided that the urban/rural payment differential would be a permanent feature of PPS, considerable debate exists about whether the PPS payment rates should vary depending on a hospital's urban or rural location. Supporters of the urban/rural payment differential argue that the historical data on hospital costs indicate that, on average, urban hospitals do have higher costs than rural hospitals. An important question, however, is why urban hospitals have higher costs. Some argue that if higher urban costs are due to certain factors which may be characteristic of urban hospitals, such as treating more severely ill patients or providing a greater intensity of services to patients, then a higher payment rate is justified. However, others argue that if the higher urban costs instead are due to greater inefficiencies in the operation of urban hospitals relative to rural hospitals, then it is not appropriate for urban hospitals to receive higher Medicare payments to cover these higher costs.

Opponents of the urban/rural payment differential argue that PPS is a national payment system which, after the transition period, will be paying hospitals on the basis of national payment rates; therefore, a hospital's geographic location should not determine its payment amount. Rural hospitals argue that their fixed costs are sometimes even greater than those of urban hospitals since they must maintain certain services even though the demand (and thus the payment) for such services may fluctuate. Rural hospitals located across an MSA boundary line from an urban hospital argue that the prices they pay for wages, services, and supplies are no different from those paid by the nearby urban hospitals located within an MSA, although the urban hospitals are paid a higher payment rate.

C. The Wage Index

P.L. 98-21 required that the PPS payment rates be adjusted for different area wage levels: "The Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs ... for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level."

HHS developed a wage index which reflected the average hospital wage level in the geographic area in which a hospital was located compared to the national average hospital wage level. The index was calculated based on wage and employment data from 1981 employment, wages and contributions for hospital workers maintained by the Bureau of Labor Statistics (BLS), U.S. Department of Labor. HHS developed wage indexes for each Metropolitan Statistical Area and one wage index per State for all rural areas in a State. Hospitals with higher wage indexes are paid higher PPS payment amounts.

HHS officials have acknowledged that the BLS wage data have certain limitations. The most serious is the lack of information on hours of employment. As a result, the area wage indexes produced from these data do not take into account differences in the mix of part-time and full-time employees. Rural hospitals frequently employ a greater proportion of part-time employees than do urban hospitals. Concern has been expressed that the wage index based on BLS data tends to understate actual rural wage levels. The use of a single wage index for all rural hospitals in a State is another concern for rural hospitals. Rural hospitals argue that a single wage index does not reflect any variations within the State in rural wage costs. In addition, rural hospitals located near urban areas argue that they must pay wages that are competitive with the urban areas and thus should not receive a lower wage index adjustment to their payment rate.

Because of the concerns with the BLS wage data, HHS surveyed PPS hospitals directly to obtain new wage and employment data, and developed two new wage indexes which were described in a March 29, 1985 report to Congress. One index, known as the "gross wage index," was derived from total gross hospital wages, including salaries and wages for contracted labor, interns and residents, personnel employed in nonhospital cost centers, and hospital-based physicians. P.L. 99-272, the Consolidated Omnibus Reconciliation Act of 1985 (April 7, 1986) required that HHS use the new gross wage index to adjust the PPS payment rates for hospital discharges occurring after May 1, 1986.

Although the implementation of the gross wage index, which is based on better wage and employment data, may resolve some of the wage index-related problems cited by rural hospitals, it makes no changes in, and thus does not address any problems related to, the use of MSAs to provide labor market definitions or the "boundary" problem for rural hospitals located close to urban areas. Research on the issue of labor market definition is being conducted by HHS, by ProPAC, by Health Economics Research, Inc.(for HHS and ProPAC), and by the Congressional Budget Office.

D. Outlier Payments

P.L. 98-21 required that additional amounts be paid to hospitals for atypical cases, known as "outliers," which have either (1) extremely long lengths of stay or (2) extraordinarily high costs compared to most patients classified in the same DRG. Based on provisions in the law, HHS has calculated outlier payments as follows:

(1) For Fiscal Year 1985 through April 30, 1986, an outlier based on a long length of stay (or "day" outlier) would be one for which the length of stay exceeds the average length of stay for that DRG by the lesser of 22 days (17 days beginning May 1, 1986) or 1.94 standard deviations. The additional payment to a hospital for each outlier day beyond the threshold is 60 percent of the hospital's Federal payment amount for the DRG divided by the national average length of stay for the DRG.

(2) A "cost" outlier for Fiscal Year 1985 through April 30, 1986, is one that exceeds the greater of two times the hospital's Federal payment amount for the DRG or $13,000 ($13,500 beginning May 1, 1986). The additional payment for costs beyond the threshold is 60 percent of the difference between the hospital's adjusted charges for the patient and the threshold. If a hospital qualifies for an outlier payment according to both the day and cost thresholds, it is paid according to the day outlier payment methodology.

P.L. 99-272, the Consolidated Omnibus Reconciliation Act of 1985 (April 7, 1986) requires HHS to review and report to Congress by January 1, 1987, on the impact of PPS outlier and patient transfer policies on rural hospitals (particularly those with less than 100 beds), including recommendations for changes in policies that adversely affect rural hospitals.

Many hospitals, urban as well as rural, have argued that the outlier payments are not adequate to cover the cost of care for unusually expensive patients. They also argue that the criteria used to qualify for outlier payments are too restrictive and that using length of stay as the primary criterion for determining the outlier payment may provide a lesser payment than using the cost criteria. Rural hospitals have argued that problems with the outlier payment methodology may affect them more than urban hospitals because their often precarious financial status may make them less able to absorb any financial losses from outlier payments that do not cover their costs.

E. Sole Community Hospitals

P.L. 98-21 required that a special payment methodology be applied to sole community hospitals, which are defined as hospitals that by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals (as determined by the HHS Secretary in regulations) are the sole source of inpatient hospital services reasonably available in a geographic area.

HHS defines a sole community hospital as one located in a rural area and meeting one of the following three conditions: (1) it is located more than 50 miles from other like hospitals; (2) it is located between 25 and 50 miles from other like hospitals and meets one of the following criteria: (i) No more than 25 percent of the residents or, if data on general resident utilization are not available, no more than 25 percent of the Medicare beneficiaries in the hospital's service area are admitted to other like hospitals for care, (ii) it has less than 50 beds and the PSRO or intermediary certifies that the hospital would have met the criteria in Item (i) were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital, or (iii) because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least one month out of each year; or (3) it is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather condition, the other like hospitals are inaccessible for at least one month out of each year.

Sole community hospitals are paid permanently on the same basis as all other hospitals were paid in the first year of the transition period (Fiscal Year 1984); i.e., 75 percent of the payment is based on the hospital's actual costs and 25 percent is based on the regional Federal DRG rate. For hospital cost reporting periods beginning on or after October 1, 1983 and before October 1, 1986, P.L. 98-21 also provided that sole community hospitals can receive an additional payment amount if, due to circumstances beyond their control, they experience a decrease of more than 5 percent in their number of inpatient cases. There were 360 designated sole community hospitals as of May 6, 1986. (See Appendix, Item C and D, for lists of sole community hospitals by State.)

P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (April 7, 1986) requires HHS (effective for hospital cost reporting periods beginning October 1, 1983, and before October 1, 1989) to adjust the PPS payment rates to compensate sole community hospitals that experience a significant increase in operating costs due to the addition of new inpatient facilities or services. HHS is also required to study and report to Congress by January 1, 1987, on the effects of this provision and recommendations for a permanent mechanism to take into account needed expansions of services.

According to a study conducted by the National Center for Health Services Research and Health Care Technology Assessment, HHS, 5/ nearly all 1982 sole community hospitals (which received sole community hospital status under Medicare's pre-PPS hospital reimbursement system) were small hospitals (nearly 85 percent had fewer than 100 beds) located in rural areas.

As expressed by Kenneth A. Shull representing the American Hospital Association (AHA) in November 12, 1985 testimony before ProPAC on the impact of PPS on rural hospitals, the PPS treatment of sole community providers is inadequate for several reasons. He stated that it is difficult for many small hospitals, particularly those in the eastern United States, to obtain sole community hospital designation because of their relative proximity to other hospitals.

In addition, HHS has not developed rules specifying how hospitals could apply for a payment adjustment to compensate for decreases of more than 5 percent in inpatient volume. In an April 9, 1986, letter to HHS commenting on proposed regulations to change the hospital specific calculation in certain circumstances for sole community hospitals, AHA Executive Vice President Jack W. Owen indicated that to date, AHA is not aware of any hospital receiving this special adjustment. While expressing the possibility that no sole community hospital experienced an admission decline of more than 5 percent, the letter stated that the "more critical problem may be the failure of the original PPS rulemaking to define the exact process for requesting this adjustment and the nature of the relief that will be provided." AHA urged HHS to provide more specific information on how to obtain this payment adjustment and to support

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5/ National Center for Health Services Research and Health Care Technology Assessment. Sole Community Hospitals: Are They Different? Department of Health and Human Services Publication No. (PHS) 85-3348. Washington, U.S. Govt. Print. Off., 1985. p.3.

the AHA in their effort to seek a legislative change extending the period of time for this adjustment, which expires for hospital cost reporting periods beginning after October 1, 1986.

AHA testimony before ProPAC also stated that in many cases, the sole community provider payment adjustment (75 percent hospital specific rate and 25 percent regional rate) provides a lower payment than the hospital would receive under the normal PPS payment rules. This situation occurs if the hospital specific rate is less than the hospital's regional rate or if the hospital's case mix index increases from that in the base period.

F. Regional and National Referral Centers

P.L. 98-21 required the Secretary to provide for such exceptions and adjustments to the PPS payment amounts as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas). HHS has defined such referral centers in regulations as follows: rural hospitals having 500 or more beds; (2) hospitals meeting certain criteria related to percent referrals from other hospitals and distance of patients' residence from the hospital; or (3) rural hospitals meeting certain criteria related to case mix index, number of discharges, and one of the following: staff specialty requirements, distance of patients' residence from the hospital, or percent referrals. There were 167 designated referral centers as of May 1986. (See Appendix, Items C and E, for lists of referral centers.)

Referral centers are paid on the basis of the higher urban PPS rates rather than the rural rates, since these hospitals attract patients referred from a wide geographic area because of their broad range of specialized services. Rural hospitals have argued that the criteria for classification as a referral center are too restrictive, such as the requirement that the rural hospital have a minimum number of discharges of either 6,000 (the national discharge criterion) or the median number of urban discharges for the region in which the hospital is located (which ranges from a low of 5,564 to a high of 9,928, depending on the region).

P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (April 7, 1986) permits rural osteopathic hospitals to meet the referral center discharge criterion if they have at least 3,000 discharges in a year.

G. Disproportionate Share Payments

P.L. 98-21 required the Secretary to provide for exceptions and adjustments to the prospective payment rates as the Secretary deems appropriate to take into account the needs of hospitals that serve a significantly disproportionate number of low-income patients or Medicare Part A beneficiaries. Although HHS has studied this issue, such an adjustment was never provided. P.L. 98-369 (the Deficit Reduction Act of 1984) required the Secretary, prior to December 31, 1984, to develop and publish a definition of disproportionate share hospitals and to provide a list of such hospitals to the Senate Committee on Finance and the House Committee on Ways and Means. On December 31, 1985, the Department published a definition of such hospitals in the Federal Register and provided a list of hospitals meeting the definition to the required Congressional committees.

P.L. 99-272, the Consolidated Omnibus Reconciliation Act of 1985 (April 7, 1986) requires that for discharges occurring after May 1, 1986, and before October 1, 1988, HHS must make additional payments to PPS hospitals which serve a disproportionate share of low-income patients. A hospital's percentage of low-income patients is defined as the sum of (1) the total number of inpatient days attributable to those eligible for both Federal Supplemental Security Income and Part A of Medicare divided by the total number of Medicare Part A patient days, plus (2) the number of Medicaid patient days (for those not eligible for Medicare Part A) divided by the total patient days. Urban hospitals with 100 or more beds having a low-income patient percentage of at least 15 percent will receive a PPS payment adjustment of 2.5 percent plus one-half of the difference between 15 percent and the hospital's percentage of low-income patients, up to a maximum adjustment of 15 percent. Urban hospitals with less than 100 beds having a low-income patient percentage of at least 40 percent will receive a PPS payment adjustment of 5 percent. Rural hospitals having a low-income patient percentage of a least 45 percent will receive a PPS payment adjustment of 4 percent. Urban hospitals with 100 or more beds whose net inpatient care revenues (excluding Medicare and Medicaid revenues) for indigent care from State and local government sources exceed 30 percent of total revenues will receive a PPS payment adjustment of 15 percent. The Congressional Budget Office is required to study and report to Congress by January 1, 1987, on the impact of this provision on hospitals.

III. ADDITIONAL RURAL HOSPITAL ISSUES

A. Financial Status

Some experts believe that rural hospitals may be financially more vulnerable to various cost containment measures, including Medicare's Prospective Payment System (PPS), because of their special characteristics. They point out that rural hospitals have smaller operating margins and lower occupancy rates than their urban counterparts.

Operating margins are a measure of the excess of revenues over expenses, also called profitability. Hospitals require a certain margin in order to replace or add to their existing facilities and equipment. Despite recent improvements in profitability for the hospital industry overall (see table 7 in section I above), rural hospitals have consistently had much lower operating margins than urban hospitals. 6/ The American Hospital Association argues that a hospital's reserves and its operating margins are important because hospital payment systems like PPS, as opposed to earlier cost-based reimbursement methods, put hospitals at risk for the difference between costs and the payment rate. Changes in patient volume and severity of patient illness, the AHA

6/ Cleverly, William D. Hospital Industry Analysis Report 1980-1984. Oak Brook, Illinois, Healthcare Financial Management Association, 1985, pp. 58-59, 126-129.

states, can cause significant shifts in average costs. Small hospitals are particularly at risk; according to the AHA, a single expensive outlier patient can make the difference between breaking even and running a substantial deficit. 7/

One of the reasons rural hospitals have lower operating margins may be their lower occupancy rates. One theory why rural hospitals have lower occupancy rates is that isolated hospitals must keep a cushion of beds for occasional heavy influxes of patients who cannot be easily referred elsewhere. 8/ Another reason for decreased occupancy may be increased competition from urban hospitals and their satellite facilities. A hospital with low occupancy rates must obtain revenues to cover its costs from fewer patients. This can be a problem if the payers for these patients pay a fixed rate, as does PPS. Rural hospitals on average are smaller than urban hospitals. More than 70 percent of all rural hospitals had fewer than 100 beds, in 1984. Very small hospitals may find it difficult to cut fixed costs, according to their administrators, because a hospital must have a minimum number of employees regardless of patient volume. For example, a hospital usually requires an administrator, three shifts of nurses, a laboratory technician, an x-ray technician, a medical records person, a billing clerk, cooks, and maintenance and housekeeping personnel. 9/

7/ American Hospital Association. Statement of the American Hospital Association in hearings before the Subcommittee on Health of the Committee on Finance of the United States Senate on Hospital Operating Margins, February 21, 1986, p.7.

8/ Can Rural Hospitals Survive? Washington Report on Medicine and Health Perspectives, May 6, 1985, p. 1.

9/ Lefton, Doug. Rural Hospitals Fight for Survival. American Medical News, February 9, 1985, p. 32.

Different patient demographics also may place a relative financial strain on rural hospitals. Rural residents are on average more likely to have inadequate or no health insurance. They are are also on average more likely to be older and eligible for Medicare. 10/

The Prospective Payment Assessment Commission, in its April 1, 1986 report to the Secretary of Health and Human Services, discussed another financial strain on rural hospitals: "...like their urban counterparts, rural hospitals continue to have inadequate investment levels to meet replacement of their current assets; as a result, rural hospitals may require substantial borrowing to acquire replacement assets. This level of borrowing may not be feasible in light of their financial conditions." ProPAC also stated, however, that because rural hospitals' occupancy rates are relatively low, the hospitals may not find it desirable to replace all existing assets. 11/

B. Closures and Consolidation

Rural hospitals that do not receive sufficient revenue to cover their costs are faced with few options. Some rural hospitals seek additional funds from other sources, such as their communities. If no sources are available or are inadequate to support the hospital, the hospital may be forced to close.

10/ Moscovice, Ira. Testimony presented at Rural Health Caucus hearing conducted by Senator David Durenberger, April 1, 1986. Minneapolis, University of Minnesota, 1986, p. 6.

11/ Prospective Payment Assessment Commission. Technical Appendixes to the Report and Recommendations to the Secretary, U.S. Department of Health and Human Services, April 1, 1986. Washington, U.S. Govt. Print Off., 1986, p. 69.

In 1985, according to the American Hospital Association, urban community hospital closings slightly outnumbered rural community hospital closings 28 to 21. The same statistics showed that small hospitals were the most likely candidates for closure. Nearly 80 percent of the community hospitals which closed (39 of the total 49 community hospitals closings) had fewer than 100 beds. The average community hospital which closed in 1985 had 63 beds. Only one community hospital with 300 beds or more closed in 1985. Future hospital closings are predicted to take place mainly among small, non-teaching hospitals, most of which are located in rural areas. 12/

Arguments in favor of consolidating rural inpatient care into fewer and larger hospitals are supported by studies which show that rural hospital care could be provided at a lower average cost per patient day by using larger hospitals with higher occupancy rates. 13/ However, overall expenditure savings may be small. Schwartz and Joskow estimate that closing 7 percent of all hospital beds would save approximately 1 percent of total hospital expenditures. 14/ It is also important to note that these results do not take into account any increased costs and risk of morbidity due to increased travel. 15/

12/ Moscovice, Ira, and Roger A. Rosenblatt. A Prognosis for the Rural Hospital: Part II: Are Rural Hospitals Economically Viable? The Journal of Rural Health, July 1985, p. 14.

13/ Finch, Larry E., and Jon B. Christianson. Rural Hospital Costs: An Analysis with Policy Implications. Public Health Reports, September-October 1981, p. 432.

14/ Schwartz, W. and Joskow, P. Duplicated Hospital Facilities How Much Can We Save by Consolidating Them? New England Journal of Medicine, 1980, pp. 1149-1157. As cited in Moscovice and Rosenblatt, A Prognosis for the Rural Hospital, p.14.

15/ Moscovice and Rosenblatt, A Prognosis for the Rural Hospital, p. 13.

In addition, the results cannot take into account many other effects a hospital closure can have on its community.

C. Hospitals' Impact on Community

Some say that rural hospitals, to a greater degree than urban hospitals, play a role in the community which goes beyond the provision of inpatient hospital services. A hospital attracts health care personnel to a community and often is a large employer of rural residents.

In rural areas, hospitals may be important factors in attracting health care personnel. The rural hospital is important to physicians because it serves as a workshop for those activities that require the use of sophisticated technology and specialized staff. The financial risk to physicians of starting and maintaining a medical practice with a wide variety of services is reduced. Physicians can decrease their investment in expensive, infrequently used, and rapidly outdated technology because the costs are borne by the hospital. 16/ Hospitals also are important factors in attracting registered nurses.

Hospitals may often be a rural community's first or second largest employer. The hospital's payroll is therefore an important part of the local economy.

16/ Rosenblatt and Moscovice, Rural Health Care, pp. 174-175.

IV. RURAL HOSPITAL INITIATIVES

A. Diversification

Many rural hospitals are attempting to generate new revenues by diversifying into nonacute care services. Some examples include the provision of primary health care, sometimes defined as basic medical services provided at the first or entry level of personal health care services, including the diagnosis and treatment of common illnesses and diseases; preventive health services; home care services; and uncomplicated minor surgery and emergency care. Hospital-based primary care generally involves greater emphasis on care delivered in the outpatient department or emergency room of the hospital. Several forms of hospital-based primary care in rural areas have been identified, including the hospital-based, physician-sponsored program where the hospital is linked to a multispecialty group practice (such as the Marshfield Clinic in Wisconsin); the hospital-based, hospital-sponsored program where the hospital delivers the primary care (such as Indian Health Service clinics); and the primary care satellite facility sponsored by the hospital to provide primary care in isolated areas (such as those sponsored by Rural Health Associates of Maine).

Another example of diversification is the use of what is known as the "swing bed" program to provide long-term care services in the hospital setting. A "swing bed" is one that is approved by the Medicare program for payment purposes to be used for either an acute care patient or a long-term care patient. The national swing bed program was authorized under Medicare legislation contained in P.L. 96-499, the Omnibus Reconciliation Act of 1980 (December 5, 1980). Rural hospitals with fewer than 50 beds that have been granted a certificate-of-need for long-term care services are eligible to participate in the program. Medicare payment for skilled nursing facility (SNF)-type care provided in a swing bed is made at the average rate per patient day paid for SNF routine services under the State's Medicaid program. As of July 1985, 688 hospitals were certified by Medicare to provide swing bed care. (See the Appendix, Item F, for the number of swing bed hospitals by State.)

In 1981, the Robert Wood Johnson Foundation began funding the Rural Hospital Program of Extended Care Services, a national swing bed demonstration project cosponsored by the American Hospital Association and administered by the Program in Health Policy and Management at New York University. The purpose of the demonstration is to promote the swing bed concept by setting up models of how small, rural hospitals with underutilized acute care beds can provide long-term care services in areas with a shortage of nursing homes. In 1982, hospital associations in Kansas, Mississippi, Missouri, New Mexico, and North Dakota were funded for four years to provide technical assistance to small rural hospitals in their States that meet the swing bed program requirements. In January 1983, four-year grants were made to 26 small, rural hospitals in those same 5 States to set up swing bed programs.

P.L. 96-499 required an evaluation of the swing bed program which is being conducted by the Center for Health Services Research, University of Colorado Health Sciences Center. Preliminary findings from the evaluation 17/ indicate that:

- about one-third of eligible hospitals in rural areas are certified to provide swing bed care;
- hospitals are more likely to participate in the program if they have low occupancy rates;
- serious competition between swing bed hospitals and nursing homes for long-term care patients does not appear to exist since hospital swing beds are used either to retain long-term care patients until a nursing home bed becomes available in the community or to provide subacute care to long-term care patients with more medically intense needs until the patient can be discharged home or to another institutional setting;
- hospitals generally believe that reimbursement under the program is inadequate;
- it is not possible at this time to determine whether the waiver of several SNF conditions of participation has had deleterious effects on the quality of long-term care provided in swing beds; and
- a potential weakness of the program is whether it tends to sustain unneeded rural hospitals by providing them an additional revenue source.

17/ Shaughnessy, Peter, et al. Hospital Swing Beds in the United States: Initial Findings: Executive Summary. Denver, Center for Health Services Research, University of Colorado Health Sciences Center, November 1985.

Other examples of rural hospital diversification include the establishmentof community education and wellness programs and the construction of physician office buildings and housing for the elderly.

B. Multi-Hospital Arrangements

Some rural hospitals have entered into multi-hospital arrangements (with either for-profit or not-for-profit systems) to help deal with mounting financial pressures. These arrangements can include affiliations, shared services, consortium, contract management, leases, corporate ownership with separate management, and complete ownership. According to the American Hospital Association, 452 rural hospitals were owned, leased, or sponsored by such a system in 1983, and another 442 rural hospitals were managed by such a system.

The advantages to the rural hospital of joining a multi-hospital arrangement include cost savings from joint purchasing and shared service arrangements; certain operating advantages such as increased productivity and lower staffing requirements; and improved access to capital resulting in lower borrowing costs. Disadvantages may include the rural hospital's loss of autonomy. 18/

An example of a multi-hospital arrangement that allows the rural hospital to maintain its autonomy is the regional partnership arrangement established by the Voluntary Hospitals of America Inc. (VHA), where larger hospitals are used an anchors, providing smaller hospitals with access to VHA programs and services. Another example of this networking approach is the 4-year demonstration project known as the Affordable Rural Coalition for Health (ARCH) established

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18/ Moscovice and Rosenblatt, A Prognosis for the Rural Hospital, p.17.

by the Lutheran Hospital and Homes Society (LHHS) and the Office of Rural Health of the University of North Dakota. Under this program, local LHHS hospitals (which have 50 beds on average) will act as hubs, coordinating health care services in rural areas.

Alternatives exist for the provision of health care services in rural areas without a hospital. These include the use of a network of rural clinics which are linked with a central hospital, perhaps in an urban area. One useful component of a rural health network could be the use of air ambulance services to transport high-risk patients (such as neonates, obstetrical patients, and severely traumatized accident victims) to designated hospitals having the necessary specialized services.

V. RURAL HOSPITAL LEGISLATION RELATED TO THE MEDICARE PROGRAM

Several bills pertaining to rural hospitals and the Medicare program have been introduced in the 99th Congress and are summarized below.

A. H.R. 1682 (Skelton), Introduced March 21, 1985

Effective for hospital discharges in cost reporting periods occurring, and fiscal years beginning, on or after October 1, 1985, this bill provides for a new way of calculating the payment rate under the Medicare Prospective Payment System (PPS). The PPS payment rate for any Diagnosis Related Group, or DRG (the groupings used under PPS to classify hospital inpatients according to their diagnosis) would be a blend of national and hospital specific rates based on the coefficient of variation for the DRG. The coefficient of variation reflects the relative statistical distribution, from the mean, of the costs of discharges within that DRG.

For DRGs for which the coefficient of variation is not greater than .1, the PPS payment would equal the national adjusted DRG rate; where it is 1.0 or greater, the payment would equal the hospital's target amount; and where it is greater than .1 but less than 1.0, the payment would equal a combination of the national adjusted DRG rate and the hospital's target rate, which would vary with the coefficient of variation.

The bill would eliminate the distinction in the PPS rates between urban and rural hospitals. In addition, the bill would require a new method for calculating the wage index by (1) identifying labor markets using a statistical cluster analysis to group together adjacent counties or comparable political subdivisions with similar average hourly hospital compensation rates, and (2) establishing a methodology for determining the proportion of hospital costs attributable to wages and wage-related costs and the relative hospital wage level in each identified labor market compared with the national average hospital wage level, taking into account differences among hospitals in part-time and full-time employment patterns.

B. H.R. 1745 (Sikorski), Introduced March 26, 1985

Effective upon enactment, this bill amends Medicare and Medicaid legislation to provide that payments to hospitals for the provision of skilled nursing and intermediate care services on a swing bed basis could not exceed the amounts paid by the State Medicaid program for such services to skilled nursing facilities (SNFs) or intermediate care facilities located in the same area as the hospital.

The bill changes the criteria for eligibility as a swing bed hospital from one having less than 50 beds to one having a total capacity of fewer than 50 beds, with total bed capacity defined as the number of beds that the facility has been licensed for, or that the facility was designed to hold, whichever is lower.

Before payment could be made to a swing bed hospital, the State certificate of need agency would have to determine that at least 96 percent of the beds being used for SNF services in SNFs located in the geographic region of the hospital were occupied at the time the hospital applies to be a swing bed hospital. Medicaid legislation would be amended such that the same requirement would apply to the use of swing beds for the provision of intermediate care services.

The bill requires swing bed hospitals to meet the same requirements applicable to SNFs and intermediate care facilities, including all State and Federal requirements for certification, licensing, and staff training.

The Secretary of Health and Human Services would be required to extend a swing bed agreement with a hospital beyond the initial 12-month period if the hospital meets all requirements at the time it applies for such extension.

C. H.R. 3000 (Dorgan), Introduced July 16, 1985

The bill provides additional criteria to allow hospitals to provide swing bed services under the Medicare program: the hospital must be located in a rural area, have at least 50 beds and not more than 150 beds, and must certify that the average daily census per year of individuals receiving extended care services in the hospital does not exceed 40.

No payment could be made for extended care services which are furnished after the end of the 5-day period beginning on an availability date for a bed in a skilled nursing facility, unless the patient's physician certifies that the transfer of the patient to the facility is not medically appropriate on the availability date.

D. H.R. 3767 (Tauke et al.), Introduced November 14, 1985

The bill provides an additional payment under Medicare's Prospective Payment System to certain high cost rural hospitals. To receive the additional payment, the hospital must document that the ratio of the hospital's unit inpatient costs to the unit inpatient costs for hospitals located in the nearest urban area, exceeds the ratio of the hospital's average Medicare payment to the average Medicare payment to hospitals in the urban area nearest the hospital. However, the additional payment to eligible rural hospitals could not result in a total payment to the hospital that exceeds the amount the hospital would have received if it had been classified as an urban hospital.

To be eligible for an additional payment under the bill, a hospital must also be located in a rural area but within 75 miles of the nearest urban area, and must meet the following two requirements: (1) the current ratio of (a) the amount by which the average Medicare payment to hospitals located in the urban area nearest the hospital exceeds the average Medicare payment to the hospital, to (b) the average Medicare payment to the hospital, must exceed that same ratio as of October 1983, and (2) the average Medicare payment to the hospital must be less than 85 percent of the average Medicare payment if the hospital had been classified as an urban hospital.

Under the bill, a hospital's request for an additional payment amount would be deemed to have been approved by the Secretary of Health and Human Services if the hospital files in a timely fashion, in a form and manner approved by the Secretary, and the Secretary has not disapproved the request within 60 days of its filing. The Secretary may require hospitals to submit to an audit to validate information contained in their application. The bill establishes an appeals process for applicatons disapproved by the Secretary.

E. S. 2410 (Baucus and Grassley), Introduced May 6, 1986. Also to be Introduced by Congressman James R. Jones et al., the First Week of May, 1986)

As described in summaries available before the introduction of the bill, the proposed bill would:

1. require the Secretary of Health and Human Services (HHS) to analyze the impact of all Medicare and Medicaid regulations on rural hospitals,

2. for sole community provider hospitals, continue the current method of payment for capital-related costs, even if the current method is changed for other hospitals,

3. require the Secretary to develop standards that ensure that Medicare outlier payments to small rural hospital and small sole community provider hospitals are no more or less than the percentage of payments made to all other hospitals,

4. require HHS to (a) set aside 10 percent of existing funds to provide for research and demonstration program activities on improvements in rural health care and (b) develop an annual agenda of projects funded under the set-aside authority,

5. require the Secretary to make timely payments to small rural hospitals (within 30 days, or less if the Medicare contractor pays other non-Medicare bills faster than 30 days), and

6. establish an office of rural health care within the office of the Administrator of Health Care Financing at HHS, which would advise the

Administrator on the effects of HHS rules, budgets, and legislative proposals on rural health care and oversee compliance with the regulatory analyses and research and demonstration project agenda provisions required by the bill.

APPENDIX

Item A	Rural Registered Community Hospitals and Beds as a Percentage of Total Registered Community Hospitals and Beds by State, 1984
Item B	Census Divisions
Item C	Number and Percentage of Sole Community Providers and Rural Referral Centers in Each State, 1984
Item D	Sole Community Providers as of May 6, 1986
Item E	Regional Referral Centers as of May 6, 1986
Item F	Distribution of Certified Swing-Bed Hospitals by State and Time Period

Item A

SELECTED RURAL HOSPITAL STATISTICS 1984
RURAL REGISTERED COMMUNITY HOSPITALS AND BEDS AS A PERCENTAGE OF TOTAL REGISTERED COMMUNITY HOSPITALS AND BEDS BY STATE

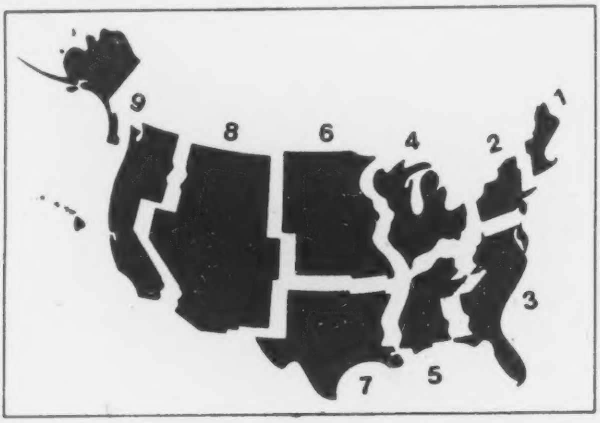
STATE	PERCENT OF HOSPS	PERCENT OF BEDS
ALABAMA	55.4	30.8
ALASKA	61.1	45.1
ARIZONA	47.5	16.5
ARKANSAS	78.3	52.6
CALIFORNIA	12.0	4.2
COLORADO	58.0	25.6
CONNECTICUT	13.9	6.1
D.C.	0.0	0.0
DELAWARE	50.0	28.4
FLORIDA	18.3	7.4
GEORGIA	57.4	35.9
HAWAII	47.4	26.4
IDAHO	93.5	83.5
ILLINOIS	36.8	16.6
INDIANA	49.1	24.8
IOWA	80.0	48.7
KANSAS	85.4	56.1
KENTUCKY	70.4	47.0
LOUISIANA	52.9	25.8
MAINE	76.2	56.5
MARYLAND	12.7	7.3
MASSACHUSETTS	13.3	8.1
MICHIGAN	39.5	17.5
MINNESOTA	67.7	39.7
MISSISSIPPI	85.3	72.4
MISSOURI	51.4	25.1
MONTANA	93.3	75.5
NEBRASKA	84.8	49.0
NEVADA	45.0	13.9
NEW HAMPSHIRE	66.7	51.5
NEW JERSEY	0.0	0.0
NEW MEXICO	74.4	49.1
NEW YORK	22.1	9.7
NORTH CAROLINA	59.2	41.1
NORTH DAKOTA	83.0	61.7
OHIO	33.5	16.1
OKLAHOMA	64.4	37.3
OREGON	53.3	33.1
PENNSYLVANIA	20.1	13.9
RHODE ISLAND	7.1	6.2
SOUTH CAROLINA	55.6	37.4
SOUTH DAKOTA	94.7	79.8
TENNESSEE	50.7	29.5
TEXAS	47.0	18.9
UTAH	59.0	22.4
VERMONT	87.5	71.5
VIRGINIA	45.0	28.6
WASHINGTON	45.7	21.4
WEST VIRGINIA	72.3	54.2
WISCONSIN	52.9	34.2

Source: American Hospital Association, 1984 Annual Survey of Hospitals.

Item B

Census Divisions

1 New England	Connecticut Maine Massachusetts	New Hampshire Rhode Island Vermont
2 Middle Atlantic	New Jersey New York	Pennsylvania
3 South Atlantic	Delaware District of Columbia Florida Georgia Maryland	North Carolina South Carolina Virginia West Virginia
4 East North Central	Illinois Indiana Michigan	Ohio Wisconsin
5 East South Central	Alabama Kentucky	Mississippi Tennessee
6 West North Central	Iowa Kansas Minnesota Missouri	Nebraska North Dakota South Dakota
7 West South Central	Arkansas Louisiana	Oklahoma Texas
8 Mountain	Arizona Colorado Idaho Montana	Nevada New Mexico Utah Wyoming
9 Pacific	Alaska California Hawaii	Oregon Washington
U.S.-Associated Areas	American Samoa Guam Marshall Islands	Puerto Rico Virgin Islands



Source: U.S. Bureau of the Census, as reported in American Hospital Association, Hospital Statistics, 1985 Edition.

Item C

Number Of Sole Community Providers And Rural Referral Centers In Each State, Percentage Of Hospitals In Each State, 1984

State	Sole Community Providers #	Sole Community Providers % Of Hospitals In State	Rural Referral Centers #	Rural Referral Centers % Of Hospitals In State	Rural Referral Center And Sole Community Provider #	Rural Referral Center And Sole Community Provider % Of Hospitals In State
Alabama	—	—	1	0.7%	—	—
Alaska	11	42.0%	6	23.1	1	3.8%
Arizona	13	16.5	—	—	—	—
Arkansas	1	1.0	—	—	—	—
California	38	6.5	1	0.2	—	—
Colorado	17	17.3	—	—	1	1.0
Connecticut	—	—	—	—	1	1.5
Delaware	—	—	1	7.1	—	—
Florida	6	2.4	2	0.8	—	—
Georgia	1	0.5	7	3.7	—	—
Hawaii	4	15.4	—	—	—	—
Idaho	3	5.8	5	9.6	—	—
Illinois	4	1.4	4	1.4	—	—
Indiana	—	—	5	3.8	—	—
Iowa	1	0.7	5	3.6	—	—
Kansas	7	4.2	2	1.2	—	—
Kentucky	6	5.0	7	5.8	2	1.7
Louisiana	5	3.2	2	1.3	—	—
Maine	9	19.1	2	4.3	—	—
Michigan	6	2.6	5	2.2	1	0.4
Minnesota	5	2.8	2	1.1	1	0.6
Mississippi	1	0.8	8	6.8	—	—
Missouri	6	3.6	1	0.6	—	—
Montana	28	41.8	3	4.5	1	1.5
Nebraska	26	23.6	2	1.8	2	1.8
Nevada	7	26.9	—	—	—	—
New Hampshire	3	8.8	2	5.9	—	—
New Mexico	21	37.5	—	—	1	1.8
North Carolina	1	0.6	9	5.7	—	—
North Dakota	21	36.2	2	3.4	—	—
Ohio	1	0.4	11	4.7	—	—
Oklahoma	7	4.9	8	5.6	1	0.6
Oregon	11	13.3	4	4.8	—	—
Pennsylvania	1	0.3	7	2.2	—	—
South Carolina	1	1.1	2	2.2	—	—
South Dakota	15	22.1	1	1.5	1	1.5
Tennessee	2	1.2	1	0.6	—	—
Texas	11	2.0	3	0.5	—	—
Utah	12	27.3	—	—	—	—
Vermont	6	31.6	1	5.3	—	—
Virginia	6	4.4	3	2.2	1	0.7
Washington	12	9.8	4	3.3	—	—
West Virginia	3	4.0	5	6.7	—	—
Wisconsin	—	—	4	2.5	—	—
Wyoming	13	41.9	—	—	—	—

Source: Fiscal Year 1984 Health Care Financing Administration Provider Specific Files, as reported in Prospective Payment Assessment Commission, Technical Appendixes to the Report and Recommendations to the Secretary, U.S. Department of Health and Human Services, April 1, 1986.

ITEM D

Sole Community Provider Hospitals
as of May 6, 1986

State	Provider Number	Hospital Name
ALASKA	02-0008	BARTLETT MEM HOSP
	02-0024	CENTRAL PENINSULA GENERAL HOSPITAL
	02-0010	CORDOVA COMMUNITY HOSPITAL
	02-0012	FAIRBANKS MEMORIAL HOSP
	02-0016	FAITH HOSP
	02-0004	KETCHIKAN GENERAL HOSPITAL
	02-0013	KODIAK ISLAND HOSPITAL
	02-0005	NORTON SOUND REGL HOSP
	02-0009	PETERSBURG GENERAL HOSPITAL
	02-0011	SEWARD GENERAL HOSP
	02-0002	SITKA COMMUNITY HOSPITAL
	02-0014	SOUTH PENINSULA HOSPITAL
	02-0007	WRANGELL GENERAL HOSPITAL
ARIZONA	03-0054	BENSON HOSP
	03-0086	BULLHEAD COMMUNITY HOSP
	03-0027	COPPER QUEEN COMMUNITY HOSPITAL
	03-0023	FLAGSTAFF HOSP MED CENTER
	03-0007	MARCUS J LAWRENCE MEMORIAL HOSP INC
	03-0055	MOHAVE GEN HOSP
	03-0048	MORENCI HOSP
	03-0068	MT GRAHAM COMMUNITY HOSP
	03-0062	NAVAPACHE HOSP
	03-0039	NEW CORNELIA HOSP
	03-0047	PAGE HOSP
	03-0067	PARKER COMMUNITY HOSP
	03-0034	SOUTHEAST ARIZONA MEDICAL CENTER
	03-0046	WHITE MOUNTAIN COMMUNITIES HOSP
	03-0012	YAVAPAI COMMUNITY HOSPITAL
	03-0013	YUMA REGIONAL MEDICAL CENTER
CALIFORNIA	05-0019	AVENAL DISTRICT HOSPITAL
	05-0352	BARTON MEMORIAL HOSP
	05-0618	BEAR VALLEY COMM HOSP

	05-0397	COALINGA DISTRICT HOSPITAL
	05-0566	EASTERN PLUMAS DISTRICT HOSP
	05-0434	ESKATON COLUSA HEALTHCARE CENTER
	05-0433	FEATHER RIVER DISTRICT HOSP
	05-0189	GEORGE L MEE MEM HOSP
	05-0092	GLENN GEN HOSP
	05-0433	INDIAN VALLEY HOSP
	05-0443	JOHN C FREMONT HOSPITAL
	05-0542	KERN VALLEY HOSPITAL
	05-0273	KLAMATH/TRINITY COMMUNITY HOSP
	05-0476	LAKESIDE COMM HOSP
	05-0251	LASSEN COMM HOSP
	05-0528	LOS BANOS COMM HOSP
	05-0638	MAMMOTH HOSPITAL
	05-0366	MARK TWAIN HOSP
	05-0569	MENDOCINO COAST HOSPITAL
	05-0429	MODOC MED CTR
	05-0430	MODOC MEDICAL CENTER
	05-0450	MONO GENERAL HOSP
	05-0260	MOUNTAINS COMMUNITY HOSPITAL
	05-0419	MT SHASTA COMMUNITY HOSP
	05-0469	NEEDLES DESERT COMMUNITY HOSP
	05-0015	NORTHERN INYO HOSPITAL
	05-0423	PALO VERDE HOSP
	05-0148	PLUMAS DISTRICT HOSP
	05-0539	REDBUD COMMUNITY HOSPITAL
	05-0172	REDWOOD MEMORIAL HOSP
	05-0448	RIDGECREST COMM HOSP
	05-0478	SANTA YNEZ VALLEY HOSP
	05-0417	SEASIDE HOSP + MEDICAL CLINIC
	05-0333	SENECA DISTRICT HOSP
	05-0355	SIERRA VALLEY DISTRICT HOSP
	05-0482	SOUTHERN HUMBOLDT COMM HOSP DISTRIC
	05-0388	SOUTHERN INYO HOSP
	05-0042	ST ELIZABETH COMMUNITY HOSPITAL
	05-0494	TAHOE FOREST HOSPITAL DISTRICT
	05-0379	WEST SIDE DISTRICT HOSPITAL
COLORADO	06-0057	ASPEN VALLEY HOSPITAL
	06-0042	CLAGETT MEMORIAL HOSPITAL

	06-0088	ELIZABETH KNUTSSON MEMORIAL HOSP
	06-0070	GUNNISON COUNTY PUBLIC HOSPITAL
	06-0066	HUERFANO MEMORIAL HOSP
	06-0090	KREMMLING HOSPITAL
	06-0062	LINCOLN COMMUNITY HOSPITAL
	06-0076	LOGAN COUNTY HOSPITAL
	06-0081	Mc NAMARA MERCY HOSP FAIRPLAY
	06-0046	MEMORIAL HOSPITAL
	06-0006	MONTROSE MEMORIAL HOSP
	06-0025	PIONEERS MEMORIAL HOSPITAL
	06-0007	PROWERS MEDICAL CENTER
	06-0073	RANGELY DISTRICT HOSP
	06-0049	ROUTT COUNTY MEMORIAL HOSPITAL
	06-0018	SOUTHWEST MEMORIAL HOSPITAL
	06-0043	ST JOSEPH HOSPITAL OF THE PLAINS
	06-0023	ST. MARY'S HOSP
	06-0029	ST VINCENT GENERAL HOSP
	06-0096	VAIL VALLEY MEDICAL CENTER
	06-0075	VALLEY VIEW HOSP
	06-0047	WEISBROD MEMORIAL COUNTY HOSPITAL
CONNECTICUT	07-0003	DAY-KIMBALL HOSP
FLORIDA	10-0024	FISHERMEN'S HOSP INC
	10-0027	GULF PINES HOSP
	10-0108	HAMILTON CO MEM HOSP
	10-0004	MADISON CO MEMORIAL
	10-0160	MARINERS HOSP
	10-0044	MARTIN MEMORIAL HOSP
	10-0018	NAPLES COMMUNITY HOSP INC
GEORGIA	11-0146	GILMAN HOSP
	11-0185	CHARLTON MEMORIAL HOSP
HAWAII	12-0014	G N WILCOX MEMORIAL HOSPITAL
	12-0016	HONOKAA HOSPITAL
	12-0019	KONA HOSP
	12-0015	LANAI COMM HOSP
	12-0002	MAUI MEMORIAL HOSPITAL

IDAHO	13-0024	BONNER GENERAL HOSPITAL
	13-0015	COMMUNITY HOSPITAL
	13-0021	LOST RIVERS HOSPITAL
	13-0012	MCCALL MEMORIAL HOSPITAL
ILLINOIS	14-0001	GRAHAM HOSPITAL ASSOCIATION
	14-0005	HARDIN CO GEN HOSP
	14-0112	MASON DISTRICT HOSP
	14-0058	PASSAVANT MEMORIAL AREA HOSPITAL
	14-0189	SARAH BUSH LINCOLN HEALTH CENTER
IOWA	16-0048	RINGGOLD CO HOSP
KANSAS	17-0020	HUTCHINSON HOSP CORP
	17-0166	MORTON COUNTY HOSPITAL
	17-0097	NORTHWEST KANSAS MED CENTER
	17-0084	NORTON CO HOSP
	17-0027	PRATT REGIONAL MEDICAL CTR
	17-0068	SOUTHWEST MEDICAL CTR
	17-0023	ST CATHERINE HOSP
KENTUCKY	18-0050	HARLAN APPALACHIAN REG HOSP-
	18-0029	HAZARD APPALACHIAN REG HOSP-
	18-0128	HUMANA HOSPITAL LOUISA
	18-0132	HUMANA HOSPITAL (LAKE CUMBERLAND)
	18-0129	MARY BRECKINRIDGE HOSP
	18-0028	MCDOWELL APPALACHIAN REGIONAL HOSP-
	18-0125	MORGAN CO APPALACHIAN REGIONAL HOSP
	18-0093	REGIONAL MED CTR OF HOPKIN CO.
LOUISIANA	19-0048	LADY OF THE SEA GENERAL HOSPITAL
	19-0156	MADISON PARISH HOSP
	19-0007	NATCHITOCHES PARISH HOSPITAL
	19-0059	POINTE COUPEE GEN HOSP
	19-0037	SOUTH CAMERON MEMORIAL HOSP
MAINE	20-0055	CALAIS REGIONAL HOSP
	20-0023	CHARLES A DEAN MEM HOSP
	20-0027	DOWN EAST COMM HOSP
	20-0037	FRANKLIN CO MEM HOSP

	20-0026	HOULTON REGIONAL HOSPITAL
	20-0052	NORTHERN MAINE MED CTR
	20-0063	PENOBSCOT BAY MED CTR
	20-0016	RUMFORD COMMUNITY HOSP
	20-0013	WALDO CO HOSP
MASSACHUSETTS	22-0012	CAPE COD HOSP
	22-0123	MARTHAS VINEYARD HOSP
	22-0081	NANTUCKET COTTAGE HOSP
MICHIGAN	23-0036	ALPENA GEN HOSP
	23-0239	CHIPPEWA CO WAR MEM HOSP
	23-0034	COMMUNITY MEMORIAL HOSPITAL
	23-0081	MERCY HOSPITAL
	23-0222	MIDLAND HOSPITAL ASSOCIATION
	23-0101	ST FRANCIS HOSP
	23-0100	TAWAS ST JOSEPH HOSPITAL
MINNESOTA	24-0119	COOK COUNTY NORTH SHORE HOSPITAL
	24-0072	INTERNATIONAL FALLS MEM HOSP
	24-0163	NORTHERN ITASCA HOSPITAL
	24-0088	RICE MEMORIAL HOSP
MISSISSIPPI	25-0109	NOXUBEE GEN HOSP
MISSOURI	26-0064	AUDRAIN MED CTR
	26-0182	MERCY HOSP-TRI COUNTY
	26-0189	REYNOLDS CO MEM HOSP
	26-0172	SALEM MEM DISTRICT HOSP
	26-0173	SCOTLAND CO MEM HOSP
MONTANA	27-0028	BARRETT MEMORIAL HOSPITAL
	27-0053	BIG SANDY MEDICAL CENTER
	27-0006	BROADWATER HOSPITAL
	27-0009	COMMUNITY HOSPITAL OF ANACONDA
	27-0021	COMMUNITY MEMORIAL HOSPITAL
	27-0042	DAHL MEMORIAL HOSPITAL
	27-0036	DANIELS MEMORIAL HOSPITAL
	27-0052	FALLON MEMORIAL HOSPITAL
	27-0044	FRANCES MAHON DEACONESS HOSP

	27-0070	GARFIELD COUNTY HOSPITAL
	27-0002	HOLY ROSARY HOSP
	27-0027	LIBERTY COUNTY HOSPITAL
	27-0043	MCCONE COUNTY HOSP
	27-0061	MEMORIAL HOSPITAL
	27-0073	MINERAL COUNTY HOSPITAL
	27-0068	MOUNTAINVIEW MEMORIAL HOSPITAL
	27-0032	NORTHERN MONTANA HOSPITAL
	27-0039	PONDERA MEDICAL CENTER
	27-0060	POPLAR COMMUNITY HOSPITAL
	27-0041	POWELL COUNTY MEMORIAL HOSPITAL
	27-0016	ROSEBUD COMMUNITY HOSP
	27-0017	ST. JAMES COMMUNITY HOSP
	27-0003	ST PETERS COMM HOSP
	27-0026	TOOLE COUNTY HOSPITAL
	27-0024	TRINITY HOSPITAL
	27-0033	WHEATLAND MEMORIAL HOSPITAL
NEBRASKA	28-0118	BOX BUTTE GEN HOSP
	28-0048	CHADRON COMM HOSP
	28-0021	COMMUNITY HOSP
	28-0090	COMMUNITY MEMORIAL HOSP INC
	28-0075	GORDON MEM HOSP
	28-0116	PIONEER MEM COMM HOSP
	28-0061	WEST NEBRASKA GEN HOSP
NEVADA	29-0019	CARSON-TAHOE HOSPITAL
	29-0006	CHURCHILL PUBLIC HOSPITAL
	29-0027	GROVER C DILS MED CTR
	29-0016	HUMBOLDT GENERAL HOSPITAL
	29-0002	LYON HEALTH CENTER HOSPITAL
	29-0015	MT GRANT GENERAL HOSPITAL
	29-0011	PERSHING GENERAL HOSP
NEW HAMPSHIRE	30-0022	ANDROSCOGGIN VALLEY HOSPITAL
	30-0006	HUGGINS HOSPITAL
	30-0015	MEMORIAL HOSPITAL I P ECUL
	30-0010	SCEVA SPEARE MEM HOSP

NEW MEXICO	32-0030	ARTESIA GEN HOSP
	32-0053	BELEN GEN HOSP
	32-0037	CIBOLA GEN HOSP
	32-0011	ESPANOLA HOSP
	32-0004	GERALD CHAMPION HOSP
	32-0067	GUADALUPE GENERAL HOSP
	32-0063	GUADALUPE MEDICAL CTR
	32-0013	HOLY CROSS HOSP
	32-0065	LEA REGIONAL HOSP
	32-0033	LOS ALAMOS MEDICAL CENTER
	32-0018	MEMORIAL GENERAL HOSP
	32-0003	NORTHEASTERN REGIONAL HOSP
	32-0049	NORTHERN COLFAX CO HOSP
	32-0036	REHOBOTH CHRISTIAN HOSP
	32-0023	ROOSEVELT GENERAL HOSPITAL
	32-0046	RUIDOSO HONDO VALLEY GEN HOSP
	32-0005	SAN JUAN HOSP
	32-0002	ST VINCENT HOSP
	32-0048	UNION CO GENERAL HOSP
NORTH CAROLINA	34-0146	HIGHLANDS-CASHIERS HOSP- INC
NORTH DAKOTA	35-0056	CAVALIER COUNTY MEM HOSP
	35-0031	CITY HOSPITAL
	35-0037	DICKEY COUNTY MEMORIAL HOSP
	35-0045	GOLDEN VALLEY COUNTY HOSPITAL
	35-0010	GOOD SAMARITAN HOSPITAL
	35-0039	HAZEN MEMORIAL HOSPITAL
	35-0027	HILLSBORO COMMUNITY HOSP
	35-0009	JAMESTOWN HOSPITAL
	35-0058	LINTON HOSPITAL
	35-0049	MCINTOSH COUNTY MEMORIAL HOSPITAL
	35-0013	MERCY HOSPITAL
	35-0017	MERCY HOSPITAL
	35-0030	MERCY HOSPITAL
	35-0048	ROLETTE COMMUNITY HOSPITAL
	35-0024	ROLLA COMM HOSPITAL
	35-0018	ST ALOISIUS HOSPITAL
	35-0007	ST ANDREWS HOSP
	35-0003	ST JOSEPH'S HOSPITAL

	35-0014	TOWNER CO MEM HOSP
	35-0033	UNION HOSP
	35-0019	UNITED HOSP
	35-0051	WISHEK COMMUNITY HOSP
OHIO	36-0109	COSHOCTON COUNTY MEMORIAL HOSPITAL
OKLAHOMA	37-0168	E P CLAPPER MEMORIAL MED CTR
	37-0022	JACKSON CO. MEMORIAL HOSP
	37-0125	MANGUM CITY HOSPITAL
	37-0048	MCCURTAIN MEMORIAL HOSPITAL
	37-0007	NEWMAN MEM HOSP
	37-0156	PAULS VALLEY GEN HOSP
	37-0139	PERRY MEM HOSP
	37-0089	TAHLEQUAH CITY HOSP
OREGON	38-0078	BLUE MOUNTAIN HOSP
	38-0072	CURRY GENERAL HOSPITAL
	38-0039	EASTMORELAND GENERAL HOSPITAL
	38-0035	GRANDE RONDE HOSPITAL
	38-0043	HARVEY E RINEHART HOSP-
	38-0083	NORTH LINCOLN HOSPITAL
	38-0019	PIONEER MEMORIAL HOSPITAL
	38-0011	ST ELIZABETH COMMUNITY HOSPITAL
	38-0023	THE GOOD SHEPHERD HOSP
	38-0070	TILLAMOOK COUNTY GENERAL HOSP
	38-0031	WALLOWA MEM HOSP
PENNSYLVANIA	39-0130	MINERS HOSP OF NORTH CAMBRIA
SOUTH CAROLINA	42-0080	HILTON HEAD HOSP
SOUTH DAKOTA	43-0043	BAPTIST HOSPITAL
	43-0076	BENNETT COUNTY MEMORIAL HOSPITAL
	43-0034	COMMUNITY MEMORIAL HOSPITAL
	43-0051	CUSTER COMMUNITY HOSPITAL
	43-0038	DAY COUNTY HOSPITAL
	43-0065	DEUEL COUNTY MEMORIAL HOSPITAL
	43-0039	DOUGLAS COUNTY MEMORIAL HOSPITAL
	43-0025	FAULK COUNTY MEMORIAL HOSPITAL

	43-0042	GETTYSBURG MEMORIAL HOSPITAL
	43-0060	HOLY INFANT HOSPITAL
	43-0011	HURON REGIONAL MEDICAL CTR
	43-0007	MADISON COMMUNITY HOSPITAL
	43-0022	MARSHALL COUNTY MEMOR HOSP
	43-0018	MID-DAKOTA HOSPITAL
	43-0077	RAPID CITY REGIONAL HOSP
	43-0012	SACRED HEART HOSP
	43-0044	SOUTHERN HILLS GENERAL HOSPITAL
	43-0015	ST MARYS HOSP
TENNESSEE	44-0083	FENTRESS CO GENERAL HOSP
	44-0180	JELLICO COMM HOSP
TEXAS	45-0150	BIG BEND MEMORIAL HOSP
	45-0587	BROWNWOOD REGIONAL HOSPITAL
	45-0355	COON MEM HOSP
	45-0322	GENERAL HOSP
	45-0583	KIMBLE HOSPITAL
	45-0092	MAVERICK CO HOSP DISTRICT
	45-0210	PANOLA GEN HOSP
	45-0178	PECOS CO MEM HOSP
	45-0177	UVALDE MEM HOSPITAL
	45-0246	WAGNER GENERAL HOSP
	45-0050	WARD MEMORIAL HOSP
UTAH	46-0016	ALLEN MEM HOSP
	46-0030	ASHLEY VALLEY HOSP
	46-0011	CARBON HOSPITAL
	46-0021	DIXIE MEDICAL CENTER
	46-0019	DUCHESNE COUNTY HOSPITAL
	46-0022	FILLMORE LATTER-DAY SAINTS HOSP
	46-0024	MONUMENT VALLEY HOSP
	46-0033	PANGUITCH LATTER-DAY SAINTS HOSP
	46-0020	SAN JUAN CO HOSP
	46-0029	SANPETE LATTER-DAY SAINTS HOSP
	46-0007	VALLEY VIEW MEDICAL CENTER
	46-0036	WASATCH COUNTY HOSPITAL
	46-0027	WEST MILLARD HOSP

VERMONT	47-0010	COPLEY HOSP
	47-0004	GIFFORD MEM HOSP
	47-0008	NORTH COUNTRY HOSP
	47-0024	NORTHWESTERN MEDICAL CENTER INC
	47-0006	PORTER MEDICAL CENTER INC
	47-0005	RUTLAND HOSP
VIRGINIA	49-0126	ALLEGHENY HOSPITAL
	49-0099	BATH COUNTY COMMUNITY HOSPITAL
	49-0022	MARY WASHINGTON HOSP
	49-0037	NORTHAMPTON-ACCOMACK MEMORIAL HOSPI
	49-0123	RAPPAHANNOCK GEN HOSP
	49-0090	SOUTHSIDE COMM HOSP
	49-0084	TIDEWATER MEMORIAL HOSP
WASHINGTON	50-0094	DAYTON GENERAL HOSPITAL
	50-0098	FERRY CO MEM HOSP
	50-0090	GARFIELD MEMORIAL HOSPITAL
	50-0059	JEFFERSON GENERAL HOSPITAL
	50-0085	KLICKITAT VALLEY HOSPITAL
	50-0061	MARK E REED MEM HOSP
	50-0073	MORTON GENERAL HOSP INC
	50-0100	MT LINTON HOSPITAL
	50-0028	NORTH VALLEY HOSPITAL
	50-0096	OCEAN BEACH HOSPITAL
	50-0101	RITZVILLE MEMORIAL HOSPITAL
	50-0069	WILLAPA HARBOR HOSPITAL
WEST VIRGINIA	51-0018	JACKSON GENERAL HOSP
	51-0028	MONTGOMERY GENERAL HOSPITAL
	51-0081	ROANE GEN HOSP
WYOMING	53-0002	CAMPBELL CO. MEMORIAL HOSP
	53-0031	CROOK COUNTY MEM HOSPITAL
	53-0025	IVINSON MEMORIAL HOSPITAL
	53-0004	MEMORIAL HOSP OF HOT SPRINGS
	53-0011	MEMORIAL HOSF OF SWEETWATER CO
	53-0002	MEMORIAL HOSPITAL OF CAMPBELL COUNT
	53-0009	MEMORIAL HOSPITAL OF CARBON COUNTY
	53-0006	MEMORIAL HOSPITAL OF SHERIDAN COUNT

53-0021	MEMORIAL HOSPITAL OF UINTA CO
53-0012	NATRONA COUNTY MEMORIAL HOSPITAL
53-0027	NIOBRARA MEMORIAL HOSP
53-0017	SOUTH LINCOLN HOSPIAL DISTRICT
53-0015	ST JOHN S HOSP
53-0023	STAR VALLEY HOSPITAL
53-0016	WEST PARK COUNTY HOSPITAL
53-0003	WESTON COUNTY MEMORIAL HOSPITAL

NOTE: Based on information from the September 1985 HCFA Provider-Specific File, updated to May 6, 1986 through telephone conversations with HCFA staff.

Table prepared by Congressional Research Service, Education and Public Welfare Division

ITEM E

Regional Referral Centers

State	Provider Number	Hospital Name
ALABAMA	01-0029	EAST ALABAMA MEDICAL CTR
	01-0118	SELMA MED CTR HOSP
ALASKA	02-0012	FAIRBANKS MEMORIAL HSP
ARKANSAS	04-0014	CENTRAL ARKANSAS GEN HOSP
	04-0069	CHICKASAWBA HOSP
	04-0078	OUACHITA MEM HOSP
	04-0020	ST BERNARDS REGIONAL MED CTR
	04-0041	ST MARYS HOSPITAL INC
	04-0098	UNION MEDICAL CENTER
	04-0088	WARNER BROWN HOSP
CONNECTICUT	07-0003	DAY-KIMBALL HOSP
CALIFORNIA	05-0506	SIERRA VISTA HOSP
COLORADO	06-0023	ST. MARY'S HOSP & MED CTR
DELAWARE	08-0004	KENT GEN HOSP
FLORIDA	10-0236	FAWCETT MEM HOSP
	10-0105	INDIAN RIVER MEMORIAL HOSP-
GEORGIA	11-0054	FLOYD CO MEDICAL CENTER
	11-0025	GLYNN-BRUNSWICK HOSP
	11-0001	HAMILTON MEDICAL CENTER
	11-0038	JOHN D ARCHBOLD MEM HOSP
	11-0122	SOUTH GEORGIA MEDICAL CENTER
	11-0095	TIFT GEN HOSP
	11-0016	WEST GEORGIA MEDICAL CENTER INC

IDAHO	13-0028	BANNOCK MEMORIAL HOSPITAL
	13-0014	CALDWELL MEM HOSP
	13-0018	IDAHO FALLS LDS HOSP
	13-0013	MERCY MEDICAL CENTER
	13-0003	ST JOSEPH S HOSPITAL
ILLINOIS	14-0015	BLESSING HOSP
	14-0160	FREEPORT MEMORIAL HOSPITAL
	14-0164	MEMORIAL HOSPITAL
	14-0064	ST MARY'S HOSPITAL
INDIANA	15-0112	BARTHOLOMEW COUNTY HOSPITAL
	15-0075	CAYLOR-NICKEL HOSP
	15-0006	LA PORTE HOSP
	15-0011	MARION GENERAL HOSPITAL
	15-0048	REID MEMORIAL HOSPITAL INC
IOWA	16-0057	BURLINGTON MED CTR
	16-0030	GREELEY MARY MEM HOSP
	16-0001	MARSHALTOWN AREA COMM HOSP
	16-0089	OTTUMWA HOSP
	16-0064	ST JOSEPH MERCY HOSP
	16-0016	TRINITY REG HOSP
KANSAS	17-0012	ASBURY HOSP
	17-0144	HALSTEAD HOSP
KENTUCKY	18-0048	EPHRAIM MC DOWELL MEM HOSP
	18-0005	HIGHLANDS REGIONAL MEDICAL CENTER
	18-0132	HUMANA HOSP LAKE CUMB.
	18-0102	LOURDES HOSP
	18-0127	KING'S DAUGHTERS MEM. HOSP
	18-0027	MURRAY-CALLOWAY CO HOSP
	18-0049	PATTIE A CLAY INFIRMARY
	18-0093	REGIONAL MED CTR
	18-0013	THE MEDICAL CTR AT BOWLING GREEN
	18-0104	WESTERN BAPTIST HOSP
	18-0069	WILLIAMSON APPALACHIAN REG HOSP-
LOUISIANA	19-0086	LINCOLN GENERAL HOSP
	19-0017	OPELOUSAS GENERAL HOSPITAL

MAINE	20-0015	KENNEBEC VALLEY MED CTR
	20-0039	MID-MAINE MEDICAL CENTER
MICHIGAN	23-0036	ALPENA GENERAL HOSP
	23-0022	COMMUNITY HEALTH CENTER
	23-0030	GRATIOT COMMUNITY HOSPITAL
	23-0097	JAMES DECKER MUNSON HOSP
	23-0054	MARQUETTE GENERAL HOSPITAL
	23-0105	NORTHERN MICHIGAN HOSPITALS
MINNESOTA	24-0093	IMMANUEL HOSP ST JOSEPHS UNIT
	24-0088	RICE MEMORIAL HOSP
	24-0075	ST JOSEPHS HOSP
MISSISSIPPI	25-0082	DELTA MEDICAL CTR
	25-0081	F G RILEY HOSP
	25-0078	FORREST CO GEN HOSP
	25-0100	GOLDEN TRIANGLE REGIONAL MEDICAL CT
	25-0104	JEFF ANDERSON REGIONAL MEDICAL CTR
	25-0094	METHODIST HOSP
	25-0004	NORTH MISSISSIPPI MEDICAL CENTER
	25-0069	RUSH FOUNDATION HOSP
MISSOURI	26-0183	ST FRANCIS MED CTR
MONTANA	27-0051	KALISPELL REGIONAL HOSPITAL
	27-0023	MISSOULA COMMUNITY HOSPITAL
	27-0017	ST. JAMES COMMUNITY HOSP
	27-0014	ST PATRICK HOSPITAL
NEBRASKA	28-0009	GOOD SAMARITAN HOSP
	28-0023	ST FRANCIS MEDICAL CTR
	28-0061	WEST NEBRASKA GENERAL HOSP
NEW HAMPSHIRE	30-0019	CHESHIRE MEDICAL CENTER
	30-0003	MARY HITCHCOCK MEM HOSP
NEW MEXICO	32-0063	GUADALUPE MED. CTR.
	32-0065	LEA REGIONAL HOSP.

NEW YORK	33-0224	BENEDICTINE HOSP
	33-0136	MARY IMOGENE BASSETT HOSP
NORTH CAROLINA	34-0109	ALBEMARLE HOSP
	34-0021	CLEVELAND MEMORIAL HOSP- INC
	34-0131	CRAVEN CO HOSP
	34-0090	JOHNSTON MEMORIAL HOSP-
	34-0115	MOORE MEM HOSP
	34-0147	NASH GENERAL HOSP
	34-0040	PITT CO. HOSP
	34-0013	RUTHERFORD HOSP INC
	34-0050	SOUTHEASTERN GENERAL HOSP-
	34-0126	WILSON MEMORIAL HOSP-
NORTH DAKOTA	35-0006	ST JOSEPH S HOSPITAL
	35-0043	TRINITY MEDICAL CENTER
OHIO	36-0125	ASHTABULA GENERAL HOSP
	36-0193	BETHESDA HOSP ASSOC
	36-0095	BLANCHARD VALLEY HOSPITAL
	36-0180	CLEVELAND CLINIC HOSP
	36-0028	COMMUNITY MEDCENTER HOSPITAL
	36-0096	EAST LIVERPOOL CITY HOSP
	36-0039	GOOD SAMARITAN HOSP
	36-0054	HOLZER HOSP
	36-0011	MARION GENERAL HOSPITAL
	36-0159	MEDICAL CENTER HOSPITAL
	36-0185	SALEM COMMUNITY HOSP
	36-0008	SCIOTO MEMORIAL HOSP
	36-0010	UNION HOSP
OKLAHOMA	37-0054	GRADY MEM HOSP
	37-0022	JACKSON CO. MEM HOSP
	37-0018	JANE PHILLIPS EPISCOPAL MEM MED CTR
	37-0034	MC ALESTER GEN HOSP
	37-0047	MEMORIAL HOSP OF SOUTHERN OKLAHOMA
	37-0025	MUSKOGEE GENERAL HOSP
	37-0006	ST JOSEPH REG N OK PONCA CITY CAMPU
	37-0049	STILLWATER MEDICAL CENTER
	37-0020	VALLEY VIEW HOSP AUTHORITY

OREGON	38-0090	BAY AREA HOSPITAL
	38-0014	GOOD SAMARITAN HOSP
	38-0050	MERLE WEST MED. CTR
	38-0047	ST CHARLES MED CTR
PENNSYLVANIA	39-0163	ARMSTRONG COUNTY MEMORIAL HOSPITAL
	39-0168	BUTLER MEMORIAL HOSP
	39-0006	GEISINGER MEDICAL CTR
	39-0016	JAMESON MEM HOSP
	39-0048	LEWISTON HOSP
	39-0171	OIL CITY HOSPITAL
	39-0079	ROBERT PACKER HOSP
SOUTH CAROLINA	42-0068	ORANGEBURG REGIONAL HOSP
	42-0071	SELF MEMORIAL HOSP
	42-0070	TUOMEY HOSP
SOUTH DAKOTA	43-0077	RAPID CITY REGIONAL HOSP
	43-0012	SACRED HEART HOSP
	43-0014	ST LUKES HOSP
TENNESSEE	44-0002	JACKSON-MADISON CO GENERAL HOSP-
TEXAS	45-0112	MCCUISTION REGIONAL MED CENTER
	45-0447	NAVARRO REG HOSP
	45-0007	SID PETERSON MEMORIAL HOSP
	45-0196	ST JOSEPHS HOSP INC
VERMONT	47-0005	RUTLAND HOSP
	47-0012	SOUTHWEST VERMONT MED CTR
VIRGINIA	49-0013	HALIFAX COMM HOSP
	49-0022	MARY WASHINGTON HOSP
	49-0079	MEM HOSP MARTINSVILLE
	49-0004	ROCKINGHAM MEM HOSP
	49-0005	WINCHESTER MEM HOSP

WASHINGTON	50-0016	CENTRAL WASHINGTON HOSPITAL
	50-0072	OLYMPIC MEMORIAL HOSPITAL
	50-0003	SKAGIT VALLEY HOSPITAL
	50-0041	ST JOHNS HOSP
	50-0002	ST MARY COMMUNITY HOSP
WEST VIRGINIA	51-0047	FAIRMONT GENERAL HOSPITAL
	51-0024	MONONGALIA CO GENERAL HOSP CO
	51-0006	UNITED HOSP CTR INC
	51-0001	WEST VIRGINIA UNIV HOSP
WISCONSIN	52-0088	ST AGNES HOSPITAL
	52-0028	ST CLARE HOSPITAL
	52-0037	ST JOSEPHS HOSP
	52-0002	ST MICHAELS HOSP

NOTE: Based on information from the September 1985 HCFA Provider-Specific File, updated to May 6, 1986 through telephone conversations with HCFA staff.

Table prepared by Congressional Research Service, Education and Public Welfare Division

Item F

Distribution of Certified Swing-Bed Hospitals by State and Time Period.

State	Number of Hospitals Certified for Swing-Bed Care 12/83	3/84	7/84	10/84	12/84	7/85
Alabama	0	0	0	0	0	0
Alaska	1	1	1	2	2	6[b]
Arizona	0	4	6	6	6	6
Arkansas	1	1	5	8	16	25
California	3	3	4	5	6	6
Colorado	2	9	13	15	16	23[b]
Connecticut	0	0	0	0	0	0
Delaware	0	0	0	0	0	0
Washington D.C.	0	0	0	0	0	0
Florida	0	0	0	0	0	0
Georgia	0	3	4	5	6	9
Hawaii	2	2	2	2	2	1[b]
Idaho	3	3	4	4	4	9[b]
Illinois	0	1	2	5	8	16
Indiana	1	1	2	2	2	4
Iowa	33	37	44	44[a]	86	92[c]
Kansas	7	10	16	16[a]	40	63[b]
Kentucky	1	0	1	1	1	1[b]
Louisiana	0	0	0	1	1	4
Maine	0	0	0	0	0	0
Maryland	0	0	0	0	0	0
Massachusetts	0	0	0	0	0	0
Michigan	0	0	0	0	0	0
Minnesota	3	4	24	56	63	79
Mississippi	4	4	4	4	8	30[b]
Missouri	7	13	16	16[a]	32	44
Montana	9	13	17	19	20	26
Nebraska	5	3	5	5[a]	14	36[c]
Nevada	4	4	4	4	4	3[b]
New Hampshire	2	2	2	2	2	2
New Jersey	0	0	0	0	0	0
New Mexico	8	8	8	9	9	13[b]
New York	0	0	0	0	0	0
North Carolina	1	4	7	7	7	8
North Dakota	14	20	20	21	21	29[b]
Ohio	0	0	0	2	2	2
Oklahoma	1	1	1	1	4	13
Oregon	0	0	0	0	0	0
Pennsylvania	0	0	0	0	0	0
Rhode Island	0	0	0	0	0	0
South Carolina	0	0	0	0	0	7
South Dakota	19	20	21	22	23	27[b]
Tennessee	0	1	1	3	3	7
Texas	2	2	4	8	17	26
Utah	7	7	7	8	8	10[b]
Vermont	0	0	0	0	0	1[b]
Virginia	0	0	0	0	0	0
Washington	2	5	8	8	9	10[b]
West Virginia	0	0	0	0	0	0
Wisconsin	6	7	15	16	24	38
Wyoming	1	5	5	5	5	12[b]
TOTALS	149	198	273	332	471	688

[a] These counts are based on July 1984 data due to temporary record-keeping problems at the Kansas HCFA Office.

[b] States that provided Medicaid reimbursement for swing-bed care at both the skilled and intermediate levels, as of late 1984 or early 1985.

[c] Medicaid swing-bed reimbursement at the skilled level only.

Source: Health Care Financing Administration Regional Offices, as reported in Shaughnessy, Peter, et al. Hospital Swing Beds in the United States: Initial Findings; Executive Summary. Denver, Center for Health Services Research, University of Colorado Health Sciences Center, November 1985.

Senator DURENBERGER. Good morning gentlemen and women, today's hearing will examine the effect of the Medicare prospect of payment system on rural hospitals and more broadly, we will also examine the concerns that we all have as Americans about the effects of the changing health care system on access to health care in rural America.

Last month I held hearings and participated in conferences back in Minnesota, Wisconsin, and Illinois, focusing on rural health. Through these experiences and many roundtables, and one on one discussions on rural areas over the past couple of years, it has become clear to me and other members of the subcommittee, like Senator Baucus, from Montana, that the face of rural health care delivery is changing significantly. Several factors appear to be at work. Not only the ongoing process of Medicare reform, but the nationwide crises of the rural economy, the growing population of elderly, even the increased demand for variety of services, including mental health.

First the financial crises of American agriculture and its dramatic effect on farmers, the rural business community, and the rural governments is taking its toll on rural health care. Net farm income fell nationwide nearly one-third from 1979 to 1983. The average farmer in southwestern Minnesota had a taxable income of just about $5,500 in 1985. At the same time, farm land values have plummeted; again in southwestern Minnesota the sale of farm land averaged $2,200 in 1979, rose to nearly $3,000 by 1981, and then dropped to $955 per acre in 1985.

Keep in mind that property taxes are responsible for more than 20 percent of all local government revenues. That means less funding for central community services.

Health insurance in routine and preventive health care are often neglected when family finances are put under stress. Most people in rural areas are self-employed or they work for small employers who might not be able to offer employees tax-subsidized health insurance plans.

Clearly the question of whether a major purchase, like health insurance is made the pretax dollars or after tax dollars is an important factor in determining the priorities of a family budget.

Rural Americans as a group are more likely to do without health insurance than are city dwellers. In my State of Minnesota, the number of rural uninsured is double the urban rate. This in part has translated into $21 million worth of uncompensated care given by Minnesota hospitals in 1985, and $25 million have been written off as bad debts.

Nationwide the cost of uncompensated care by community hospitals was $6.2 billion in 1982. Over 45 percent of the Nation's hospitals are government owned, which usually means city or county governments.

With less and less money to work with, local government officials are digging down into nearly empty pockets to cover the charity care their local hospitals are offering to farmers, and others, who are going broke and are without insurance.

This scenario is repeating itself over and over in rural communities across the country. Some States like Montana, Kansas, and

Oklahoma are facing the double whammy of agricultural crises and an oil price slump.

So, you can multiply what I have said about Minnesota by umpteen percent for them. On top of the financial woes, rural America is growing old at a rapid rate. Since 1960, the total rural population grew 10 percent, but the older group, those over age 65, grew 30 percent—three times as fast.

As this older group needs and uses more health services than the younger, it will tax an already financially burdened rural health delivery system. Using my State again as an example, as of the second quarter of 1985, Medicare patients accounted for 24 percent of total admissions of hospitals in Minneapolis and St. Paul, where half our population lives. While in the most rural counties of Minnesota, where the other half live, more than 42 percent—almost twice as many admissions—were Medicare.

There is another factor I mentioned earlier that has been getting short shrift in the health policy debate, that the crises in the rural economy is not only affecting the financial stability of hospitals and medical professionals and the ability of rural residents to get adequate medical care, but it is also putting incredible stress on the mental health of rural Americans.

At my hearing in Minneapolis, I heard from a mental health worker from southwestern Minnesota, who reported that between 1983 and 1985, her mental health center experienced a 30-percent increase in out-patient mental health services, and a 330-percent increase in the number of people using the center's 24-hour crises drop-in program.

It is clear, both Medicare and Medicaid have a long way to go in recognizing the importance of mental health services. The time has come for us to start thinking about mental health as prevention and treating these services with the same concern as we do for acute Medicare and Medicaid services.

Now, how does the prospective payment system fit into this picture of rural health care? Congress made the decision to gradually phase in PPS so problems could surface and be addressed before the system is 100 percent in place.

Some of the rural problems we have been able to fix and some still need a lot of work. ProPAC's April report to HHS warns any problem rural hospitals are now facing will only be exacerbated when PPS is totally in place. I have outlined the reasons this morning, and I know our witnesses today will elaborate on them. Rural hospitals are especially sensitive to changes in Medicare payment rules.

According to the HHS inspector general's report submitted in the hearing we chaired February 18 regarding hospital profits, it is true that both rural and urban hospitals are profiting under prospective payment. But, the average net profit realized by rural hospitals is a fraction in my State of Minnesota, one-tenth of the average profit, of the urban hospitals.

It is this slim Medicare profit margin that is literally keeping rural hospitals alive.

Many rural hospitals have also benefited from being designated as sole community provider or regional referral centers or by participating in the Swing Bed Program. There is also something that

I worked on last year which is now in the Budget Reconciliation Act, that will require the Secretary to implement the new gross area wage index.

Beyond these the system needs further reform. Rural hospitals that are classified as rural for DRG payments, but are close to urban areas and urban hospitals are treated unfairly. On top of that rural hospitals are more financially vulnerable to fluctuations of patient volume and case mix. And, we are still waiting on a decent severity of illness index for rural hospitals.

So, we have our work cut out for us in the up coming months to give a fair shake to rural hospitals and correcting true rural-urban inequities in PPS. I think we are going to do it for some reason or other in a new and different spirit around this place, just in the last couple of days. I am sure that those who thought the administration was going to make law this year on a budget will have another thing coming, thanks to what Dan Rostenkowski did yesterday and what we intend to do in reconciliation.

In the next couple of weeks, I trust that this hearing and the people who are the witnesses at this hearing will give us the guidance we need to accomplish that effort successfully.

With that, let us go to our first witness. Our first witness is the Honorable Wes Watkins, U.S. House of Representatives from the State of Oklahoma. Wes, take a seat in the middle, wherever it is appropriate, we appreciate your coming, and your full statement will be made a part of the record. You may proceed.

STATEMENT OF HON. WES WATKINS, U.S. HOUSE OF REPRESENTATIVES, STATE OF OKLAHOMA

Mr. **Watkins**. Thank you Mr. Chairman. First and foremost, I want to thank you, members of the committee and staff for your interest and also having this particular hearing. I think it is very timely as you have indicated.

I would like to begin by saying that rural health care is not only on the critical list, it is on the deathbed list in many of the counties in my State. We have hospitals that are actually closing the door.

Briefly, Mr. Chairman, I want to discuss how Medicare changes have affected rural hospitals in terms of the urban rule differential in the wage index. The law passed in 1983 was not all that bad. What is wrong is the lack of equity. The unfair treatment of rural hospitals under the new policy, medical diagnosis related areas specifically.

The price rates should not distinguish between rural and urban hospitals, however, they do. Rural Oklahoma hospitals receive the lowest DRG prices in the country. Inappropriate low prices for their services when compared to similar services in the urban areas. In order to kindly focus on that, I made part of my testimony a chart that I would like to make sure is part of the record.

Senator **Durenberger**. It will be made part of the record.

Mr. **Watkins**. It shows the differences between the rural hospitals in Oklahoma and the four major urban areas of our State. I think, Mr. Chairman, this solidifies the point I'm trying to make. The latest figure I have indicates that rural hospitals in Oklahoma receive Medicare payments averaging 36 percent less than urban hospitals for those same medical procedures. Let me give you an example. Gall bladder surgery at a rural Oklahoma hospital would bring approximately $2,959 in payment from Medicare. The same surgery at the Oklahoma City or Tulsa hospital would have a $4,802 Medicare reimbursement. That is completely out of line. It is this fairness and equity that I am talking about and it is this fairness and equity that you and I have got to make sure occurs if we are going to allow rural hospitals to stay in place.

Just yesterday with Senator Baucus, we had a press conference on rural hospital legislation and I pointed out, Mr. Chairman, that some rural hospitals in my district have as high as 89 percent of their patient load that is Medicare. Farm people have left and our young people have gone to college. They can't come back for jobs. The description of the population in those areas happen to be elderly and poor. As a result it has become a disaster and an undue load for those few private patients who are left in those rural areas.

Now, you cannot tell me that the costs for services in rural areas are a third less than what it costs in urban areas. Second, the wage index that is used to compute the DRG price, lacks equity also. It is not fair.

Rural hospitals compete for personnel just like all the others. Let me point out three or four examples to this committee, because I think we want to know the facts. The area wage index currently used by Health Care Financing Administration to adjust average standardized amounts to each particular locality indicates that the wages paid in rural Oklahoma are about 19.3 percent less than the wages paid in the Oklahoma City metropolitan area, and 17.4 percent less than the Tulsa metropolitan hospital area.

Now, with that fact and what HCFA is actually using, let me give you some comparisons that I have checked on personally. The starting salary for RN's in rural northwest Oklahoma receive about $11.52 per hour. Their counterparts in Oklakoma City are paid $11.46 an hour. The rural hospitals have to pay more than the urban areas. The respiratory therapists are paid $9.57 per hour in rural southwest Oklahoma and $9.49 in Oklahoma City area. And, I can give you other examples. But, all of them proves we have to pay more in rural areas.

So, they are using the wrong formulas by not providing fairness and equity. On both of the issues that I have spoken, rural America is no different basically than urban areas. Rural hospitals need to be treated with the same equity and fairness as our urban brothers and sisters receive if we are going to keep the hospitals open. And, I appreciate this committee looking into these inequities.

Another topic I would like to briefly address is the capital pass through issue. The best thing we can do is make sure we have in rural areas some of the finest equipment and be able to give the state-of-the-art facilities and services needed by our constituencies, if we are going to maintain those.

Mr. Chairman, in Oklahoma we depend upon oil and gas, and agriculture which is on its deathbed. We find that our rural hospitals are in the same position. Land prices are dropping for the first time since the Great Depression. They are voting local sales tax to try and maintain these facilities. Health care is dying in Oklahoma. Rural hospitals are dying with a silent death, unless you and I and others are not only willing to sound off but willing to stand up and push legislation forward. And I want to commend you and your committee for looking into this and I know you will do more than just look into it, you will act and try and correct it.

Thank you, Mr. Chairman, for letting me join you this particular day at this Senate hearing.

Senator DURENBERGER. Thank you, Wes. I think one of the realities of, maybe a reality as we look at rural hospitals, is a lot of this change was taking place out there even before the Medicare prospective payment system came along. Part of that change was of course that certain rural hospitals in the larger cities were getting bigger, more specialists were coming on, medical specialists were coming to these hospitals, so, there is a certain amount of drain off from the small hospitals to certain rural hospitals. Is that your experience in—I know that was my experience in Minnesota. Was that your experience in Oklahoma?

Mr. WATKINS. Yes, I have people that must travel 50, 60, 70 miles to visit specialists in hospital care. And, they are basically turning their former hospital care into clinics, just for the kind of care they can afford to get on an emergency basis. You described it perfectly.

Senator DURENBERGER. Would you compare a person who lives in Tulsa or Oklahoma City or Minneapolis and St. Paul with somebody who needs to travel 50 or 60 miles for one part of their service or just the fact that they can go back home sooner or later and get a rehabilitation service—that is a whole different set of costs. It is a whole set of expectations, it is a whole different set of requirements. It is a broader group of professionals that are required to deliver service with the same DRG, or whatever, as somebody who can go 1 mile or a mile and a half from one place in Tulsa to another place in Tulsa, is it not?

Mr. WATKINS. That is correct.

Senator DURENBERGER. And, also you know the inequities in the payment of physicians in rural areas. We have a dual type system and—there they get the same type of repayment into the various medical people as they do in the urban areas, so that makes it even hard to get the specialists out there to do it.

Mr. WATKINS. Mr. Chairman, I would like to make an additional point; I would be remiss if I didn't, because I came to Congress fighting for rural America, for rural development. Evidently, I have done a terrible job since, it seems like it has gone the other way. I can preach the gospel of rural America and do everything I can, but some people do not understand. I see what is happening in rural America, and it is literally being pulled apart at the seams; the values are being destroyed that allowed this country to stand strong. Now, Mr. Chairman, a lot of that we cannot turn around immediately, but I want to point out one thing as I tried to yesterday.

I have been trying to get industry into the rural areas, so our farmers can have a part-time job or a full-time job and they can farm part time. Mr. Chairman, if we lose our hospitals, we might as well give up trying to attract industry to rural America.

If we lose our rural hospitals, then they are not going to come to the rural areas and locate their plants or branch plants because they have no health care for their employees. So, I think it is vital that we do everything we can to keep health care within commuting distance. A viable health care program is needed if we are going to rebuild rural America.

Senator Durenberger. Wes, I am glad to hear you say that you came to Congress to help rural America and near the end of this month, precisely about May 21 or 22 the study that we are doing in the Intergovernmental Relations Subcommittee on Impact and Change in Rural America is going to be ready. And, I think what that study is going to tell us is that there are very serious problems that face this country, when it suits its policies to the scale of urban America and then tries to apply those same policies, whether they are health policies or telephone bills or transportation or you name it to a different kind of society that exists in rural America. One that is heavily impacted by deregulation, heavily impacted by foreign competition for products and all that sort of thing.

I think it is going to show us the dimensions of the problem that you face in trying to help rural America cope with change and I hope that you will read the report and that maybe together on both sides here we can all take on the challenge of stopping the division in this country between urban America and rural America, which only works to the detriment—and policies that I have been watching happen in the last few years were destroying even the investment in trying to help it turnaround.

Mr. Watkins. My area has had 40 to 50 years of double-digit unemployment and low per capita income since cotton and coal went out. We never rebuilt, we have been in that depression since those days, when a lot of other areas were having a strong economic recovery in Oklahoma. A lot of the area I represent never had that recovery.

Senator Durenberger. Senator Baucus.

Senator Baucus. Wes, I want to thank you. Ever since I have known you, it has been 12 years now, you have been a champion of rural America. You are continuing to do that, persistently advocating the ~~cause~~ and I appreciate very much everything you have said.

Mr. Watkins. I have not let up, Max, but it does not seem like I have been hitting any homeruns. [Laughter.]

Senator Baucus. Well, as you all know we have two choices, we try or do nothing about it.

Mr. Watkins. That is right.

Senator Baucus. And you have been trying and I must say that at the press conference and at the introduction of our bill, a couple of days ago, you brought out a lot of salient points, which I thought were very compelling. I just hope, frankly, that if enough folks pick up on what you have been saying and enough other folks read or see on the television or hear on radio what you have been saying, more people will understand the problem, and we can correct it. I tip my hat to you, you have done a great job.

Mr. WATKINS. Like you say, we can leave them on welfare or we can try and build a future for them. And, we have got to build a future for them.

Senator BAUCUS. Thank you.

Mr. WATKINS. Thank you.

[The prepared written statement of Hon. Wes Watkins follows:]

Testimony of

The Honorable

Wes Watkins

U.S. House of Representatives
3rd District, Oklahoma

Before The

Subcommittee on Health

Committee on Finance
United States Senate

Friday, May 9, 1986

Mr. Chairman, and other distinguished members of the Committee, thank you for allowing me the opportunity to appear before this Subcommittee to discuss a subject that I have a deep concern about; hospitals in rural America.

Let me begin by saying, rural health care is on the critical list. Many Oklahoma rural hospitals are on that list. Granted, economic conditions has contributed to the problem. But, a reduction in oil and gas revenues happened long after our problems with rural hospitals began. Our problems began long ago, and became worse when changes were made in Medicare policy with the passage of the Social Security Amendments of 1983.

Briefly, I would like to discuss how Medicare has affected rural hospitals in terms of the urban/rural price differential, and the wage index. Additionally, I would like to discuss the capital costs issue.

The law that Congress passed in 1983 to make changes in Medicare was not a bad bill. What is wrong, is the inequitable and unfair treatment of rural hospitals under the new policy. Medical Diagnosis Related Group (DRG) price rates should not distinguish between rural and urban hospitals. Rural Oklahoma hospitals receive the lowest DRG prices in the country and an inappropriately low price for their services when compared to similar services rendered in comparable hospitals in metropolitan areas. The DRG prices established for the region in which Oklahoma is included are the lowest prices paid in any of the nine DRG regions in the country, and within that region, rates for rural hospitals are much lower than for urban hospitals.

I have attached a chart which illustrates the different amounts paid to similar hospitals in rural and urban areas for performing the same procedures. The chart compares the average prices paid in each of the four Metropolitan Statistical Areas (MSA) in Oklahoma as well as four hospitals in rural areas for each of five surgical DRG's and five medical DRG's. The hospitals selected are of similar size and provide similar services. I think you can easily see the differences in rural and urban payments.

The latest figure I have indicates that rural hospitals in Oklahoma receive medicare payments averaging 36 percent less than urban hospitals for the same medical procedures. Gall bladder surgery at a rural Oklahoma hospital would bring a $2,959 payment from Medicare; the same surgery at an Oklahoma City or Tulsa hospital would have a $4,802 Medicare reinbursement. Is this fair and equitable? How can our rural hospitals keep their doors open with these kind of discrepancies in payment?

The current system of establishing DRG prices by MSA is arbitrary and results in inequitable payment to neighboring hospitals who happen to be outside the MSA and who compete in the same labor and supply markets for their goods and services. The same service cannot cost one-third less in a neighboring institution merely because of some imaginary boundary and the Medicare program should not pay such differing amounts for essentially similar services.

Secondly, the wage index used to compute DRG prices is not equitable. Rural hospitals compete for personnel with one another and with hospitals located in nearby urban areas. In many instances, technical and professional workers have to be recruited to work in rural areas by payment of wage levels at least as high or higher than those paid in neighboring urban areas.

The area wage index currently used by the Health Care Financing Administration (HCFA) to adjust average standardized amounts to each particular locality indicates that wages paid in rural Oklahoma are about 19.3% lower than the wages paid by Oklahoma City metropolitan hospitals and 17.4% less than Tulsa metropolitan hospitals.

However, a comparison of actual average wage rates indicates that:

- Staff RN's in rural northwest Oklahoma receive $11.52 per hour in starting salary, while their counterparts in Oklahoma City receive slightly less - $11.46 per hour.
- Registered Respiratory Therapists are paid $9.57 per hour on average in rural southwest Oklahoma and $9.49 in the Oklahoma City metropolitan area - again, the urban actual wage is lower than the wage in rural Oklahoma.
- Registered Respiratory Therapists in rural northeastern Oklahoma are paid $8.99 per hour while their counterparts in the Tulsa metropolitan area are paid $8.96 per hour.
- Medical Technologists are paid $10.93 per hour on average in rural northwest Oklahoma while they are paid $10.91 in the Oklahoma City metropolitan area.

In every instance cited, the wages are lower in urban Oklahoma - than in rural Oklahoma.

The relative amounts paid by rural and urban hospitals to recruit the necessary skilled staff are not reflected in the current wage index. Further efforts are needed to achieve a more accurate reflection of the actual amounts paid by hospitals in various areas for the services of their employees. Labor costs are not higher in urban areas.

On both of the issues that I have spoken, rural America is no different than urban areas. Rural hospitals need to be treated the same as their urban counterparts. I would encourage this committee to look to correcting the inequities.

Another topic I would like to briefly address is the capital pass through issue. The best possible situation is to maintain the current methodology. This would keep the Medicare program paying its fair share for the Medicare recipient. A delay in implementation of any change in the Medicare capital reimbursement function is needed for at least another fiscal period. The surest way to close small rural hospitals is to sharply curtail a hospital's ability to maintain both state-of-the-art facilities, services and equipment. Lastly, this is a legislative issue and should not be left to the discretion of the agency.

In summary, if significant change is not made in how rural hospitals are treated under current Medicare policy, we can bid health care in rural America farewell. Their economic health is in jeopardy. I repeat, rural health care is on the critical list. Yesterday, I, along with a number of House and Senate colleagues, have introduced a bill to correct many of the inequities of the current system. Your close consideration of the bill is appreciated.

Thank you Mr. Chairman for this opportunity to testify.

OKLAHOMA HOSPITAL ASSOCIATION

Comparison of Average Medicare Prices
by Selected DRG's

DRG	Tulsa MSA	OKC MSA	Lawton MSA	Enid MSA	Rural #1	Rural #2	Rural #3	Rural #4
88 - Pneumonia	3,468	2,959	3,031	3,004	2,506	2,550	2,441	2,475
89 - COPD	3,638	3,134	3,211	3,182	2,654	2,702	2,585	2,622
127 - CHF/Shock	3,433	2,958	3,030	3,004	2,505	2,550	2,440	2,474
161 - Herniorraphy	2,331	2,009	2,058	2,038	1,701	1,732	1,657	1,680
182 - Gastrointestional Disorder	2,040	1,759	1,801	1,787	1,488	1,515	1,450	1,470
197 - Cholecystectomy	4,904	4,225	4,329	4,284	3,578	3,643	3,485	3,535
209 - Major Joint Procedure	7,558	6,511	6,671	6,608	5,514	5,613	5,371	5,447
210 - Hip/Femur Procedure	6,872	5,921	6,066	6,009	5,014	5,104	4,884	4,953
243 - Medical Back Problems	2,491	2,146	2,191	2,181	1,817	1,850	1,770	1,795
336 - TURP	3,324	2,864	2,936	2,910	2,426	2,469	2,363	2,396

Senator **DURENBERGER**. Thank you very much. The next witness is the Honorable Tom Tauke from the U.S. House of Representatives from the State of Iowa. Tom, we are also very pleased to have you with us here today. Tom is the chief author of H.R. 3767, which will provide additional payments under Medicare prospective payments system to certain high cost rural hospitals. We welcome you Tom and your commitment to rural America and your full statement will be made part of the record.

STATEMENT OF HON. THOMAS J. TAUKE, U.S. HOUSE OF REPRESENTATIVES, STATE OF IOWA

Mr. **TAUKE**. Mr. Chairman and Senator Baucus it is good to be here. I commend both of you for your leadership in the entire health care area, and specifically in the area of rural hospitals. I feel a little bit like I am preaching to the high priests of the cause, this morning.

Obviously, there is growing frustration in both the House and the Senate over the lack of effort to correct the obvious inequities that we have in the prospective payment system. Now, these inequities are not surprising. For years Congress has been aware of the fact there were potential problems with the prospective payment system.

When the legislation was first put in place and in subsequent legislation we have called for studies to look at some of the problems that would confront rural hospitals.

To date, I might point out not one of these studies has been done by the Department of Health and Human Services, and that certainly calls into question the commitment the Department has to deal with the problems that confront rural hospitals under the prospective payment system as well as its responsibility in meeting the obligations that Congress has set forth for it.

The rural hospitals, I think we have to understand, are the hub of the rural health care system. They provide more than just hospital care. In addition to acute care they are the hub of providing skilled nursing care, home health care, respite and adult day care programs and preventive programs.

So, if you lose the rural hospital, you lose all of that health care that the rural hospital provides. If you lose the rural hospital you have difficulty in attracting and retaining physicians. And, as my colleague Wes Watkins pointed out, it is very difficult to keep employers in rural areas if there is no hospital.

Yet, we see a problem as the American Hospital Association points out, where we have sharp declines in rural hospital operating margins and in admissions. Hospitals with fewer than 25 beds showed a negative 7-percent operating margin for the 10 months of 1984.

Total patient days for hospital with fewer than 50 beds dropped 19 percent in the first 10 months of 1984, with admissions dropping nearly 9 percent. Admissions for all U.S. hospitals have been dropping, which has been part of what we hope would have happened with prospective payments. They dropped 2 percent from 1982 to 1984. The admissions to the rural hospitals dropped 17 percent. So, we have the impact being much greater on rural hospitals, and in

1985 the American Hospital Association survey indicates that all these trends are continuing.

On the prospective payment system, ideally, how a hospital fares depends upon its ability to provide needed high-quality, cost-effective services and that should be the task. But, the reality for rural hospitals is quite different. They are seriously disadvantaged under this system.

In my own State, the rural-urban labor and nonlabor reimbursement differentials result in underreimbursement of many rural hospitals. The difference in the labor reimbursement is 23 percent in my State; in the nonlabor reimbursement, the difference between urban and rural is 54 percent. So, we have hospitals, for example, in Davenport, IA, and Clinton, IA, 25 miles apart, one serving a city or metropolitan area of some 500,000 and another serving a city of 30,000. They operate in essentially the same marketplace, only 20 some miles apart. They have the same labor costs, but one receives reimbursements more than a third greater than what the other receives. They just cannot make it under those circumstances.

As Wes has already mentioned this morning, legislation has been introduced to try to deal with some of the problems. You, Mr. Chairman, mentioned the bill that I had introduced, H.R. 3767. Senator Baucus, you and others, along with myself introduced another measure yesterday which would require analysis of the impact upon rural hospitals of the proposed and final regulations offered by HCFA. It retains the current law for capital cost reimbursement for sole community providers. It requires more equitable payments to rural hospitals for the outliers, because they are particularly hard hit by the outliers, among other things.

I think it is instructive to us to note that the Prospective Payment Assessment Commission Report underscored the problems posed for rural hospitals. And, with your permission, I will quote just a few relevant passages from this report, which I think sum up the case. The Prospective Payment Assessment Commission said:

> In particular the financial vulnerability of small rural hospitals to fluctuations in volume and case mix has caused concern.
>
> For larger institutions, minor fluctuations in volume and case mix are less critical. Larger hospitals can average these fluctuations from year to year and over a large number of cases. Small rural hospitals can not take advantage of this law of large numbers. If such hospitals are located in relatively isolated areas and the deteriorating financial position results in the closure of the facility, Medicare patients access to services may be severely compromised. . .
>
> In the end, the Congress or the Secretary or both may have to determine whether it is appropriate to pay slightly more money or pay differently to avoid insolvency among certain rural hospitals. It may be cost effective for Medicare to pay slightly more or slightly differently for care in these hospitals, if, by doing so, rural patients are not required to seek care in distant urban hospitals where the care is less accessible and more costly.

So, the case has been made time and again, Mr. Chairman, and I know you and others are on the cause and are pushing for action.

Thank you for this opportunity to testify.

Senator DURENBERGER. Tom, thank you very much for being here. Obviously, those of us who have been working in health policy are impressed by what people in Iowa have been doing over the last 3 or 5 years to anticipate the problems that a lot of people knew were coming to the medical professions and to the hospitals.

But, with all of that, the pressure comes on employers in Iowa, for example, to cut down the costs. To change the way people buy hospital and medical services. All of that would combine with the prospective payment system.

I take it has been sort of a sudden shock to a lot of rural hospitals. One of the problems we have in Minnesota is coping capacity. If you are a large hospital, you have a larger coping capacity than a small 50-bed hospital or less with a limited population, which is rough.

One of the things that is happening in my State, and I am curious to know the degree to which it might be happening in Iowa, is, "How do we do this transition to a national average of PPS rate more sensitively. A large hospital, that might be sort of a center of a geographic area, either directly through the hospital or through medical professionals that are located in that area, are starting to link up with small hospitals in the area. They are providing a variety of relationships that are designed to benefit both the larger hospital and the smaller.

Is that sort of thing going on in Iowa, to what degree and might there be something that you think we should be sensitive to here as we make policy in the Medicare area?

Mr. **Tauke**. Well, it is happening in Iowa. I think rural hospitals have become remarkably creative in the way they have tried to survive under some difficult circumstances. For example, in my own congressional district, St. Luke's Hospital in Cedar Rapids has established relationships with a number of rural hospitals in communities within 50 miles of Cedar Rapids. In that way, some of those hospitals have been able to survive. It has been good for St. Lukes; it has also been good for the hospitals in the rural areas. That has been very helpful.

We do, however, continue to have hospitals that are rural, more isolated, that have very high Medicare patient load levels, who are just having difficulty in making it, because they have not been able to enter into that kind of relationship or even with that they are having difficulty in surviving.

Senator **Durenberger**. I made reference in my opening statement to the fact that Medicare patients in particular and patients generally, in rural hospitals are both older and in this period of time, sicker in a sense. Based on specific reference to mental health problems.

As I look at the southern tier of Minnesota counties the ones that are closest to Iowa, the problems are bigger, because the wealth of farm families rose so high on the inflation ride in the seventies. When they fell off the edge of the cliff in the last 2 or 3 years, the third and fourth generation farmer has sort of turned on himself and took all the blame on himself and there are a whole lot of those kinds of problems that seem to be complicating the tasks of doctors and hospitals in rural areas that they do not face in urban hospitals.

Now, Iowa is like just one little part of Minnesota and you must be seeing a great deal of that kind of thing?

Mr. **Tauke**. I have a district, as you know, Senator, where the farm land prices were almost throughout the district $3,000 an acre and in many cases had risen well over $4,000 an acre. So we have experienced a very steep decline in value of that land and huge capital losses that come with that. As I indicated in my statement, 60 percent of the rural hospitals in the country, and I suspect a higher percentage in Iowa, cannot make it on the payments they receive from patients. In large part—in many cases—well over half of the patients are on Medicare. They have got to rely on outside community support. Just at the time they are getting the crunch from Medicare, all the economic problems that are confronting those rural areas have diminished the ability of the local community to provide support for those rural hospitals. That is one of the reasons they are having difficulty.

It doesn't make any sense to let those hospitals close when they provide services for a patient at 70 percent of the cost or at 60 percent of what the patient or what we will have to pay if that hospital closes, forcing the patient to go to an urban area nearby. Not only will the patient have less access to care, but it will cost us more—the Government, the taxpayer—more to care for them in the urban area. We ought to keep some of those. I am not saying there are not some that should close just because of lack of business, but I think that overall we should not let these hospitals go under; we should try to keep them, because they are the most cost-efficient, most effective, highest quality way of providing care to those people.

Senator **Durenberger**. Tom, I am wondering, have you given any thought to whether prospective payment system should be an entirely different system for small rural hospitals. That is, should we revamp the two-tier system, should we move to a regional system? Should small rural hospitals, perhaps, go back to the old cost reimbursement system as opposed to the nonsmall rural hospitals.

Mr. **Tauke**. My reaction is that we have a two-tier system right now. That is part of our problem, at least in a State like mine. The urban hospitals receive substantially more reimbursement than the rural hospitals do, because of the labor and nonlabor differentials between urban and rural. If they all received the same, the rural hospitals would be in fat city, frankly. They would be doing very well. So, I think that instead of saying should we have a two-tier system, I would say we should get rid of the two-tier system——

Senator **Durenberger**. I said should we revamp the two-tier system?

Mr. **Tauke**. Maybe—I do not know that we should revamp it. I think that the prospective payment system can work in its basic form for rural hospitals if we make some of the changes that have been called for some time by you and me and a number of others. I am not ready to say that I would sell out the system, yet. I think it can be made to work for rural areas. The problem is that the tinkering we have done so far in the system has been to the disadvantage of rural areas and that is hurting.

Senator **Durenberger**. Thank you. George Mitchell.

Senator **Mitchell**. Thank you, Mr. Chairman. No questions, thank you.

Senator **Durenberger**. Tom, thank you very much for your testimony.

Mr. **Tauke**. Senators, Mr. Chairman, thank you so much.

Senator **Durenberger**. We appreciate it a great deal.

[The prepared written statement of Hon. Thomas Tauke follows:]

Statement of the Honorable Thomas J. Tauke
Before the Senate Finance Committee
"Impact of the Prospective Payment System
on Rural Hospitals"
May 9, 1986

Mr. Chairman, I commend you for convening this hearing on the impact of the prospective payment system on rural hospitals, and I appreciate the opportunity you have given me to testify. But I must admit to the deep frustration I feel and I know many other members of Congress from rural areas share over the lack of action to correct obvious inequities in the prospective payment system's treatment of rural hospitals.

Congress was aware that the prospective payment system could create problems for rural hospitals and mandated studies on a number of rural hospital concerns in the 1983 prospective payment implementing legislation. Several other studies were mandated in the 1985 Deficit Reduction Act. To date, not one of these studies has emerged from the Department of Health and Human Services. This record of inaction and the enormous struggle required to wrest the report on the revision of the seriously flawed area wage indexes from the Department and the Office of Management and Budget call into serious question this Administration's commitment to the preservation of rural Americans' access to high-quality, community-based health care services.

The rural hospital is the hub of the rural health care system, and many rural hospitals are in serious trouble, threatening the fabric and quality of our rural health care delivery system and the overall quality of life in rural areas.

In addition to providing community-based acute care services, rural hospitals often provide skilled nursing care, home health care services, preventive services, respite care services, and other services. It is difficult to attract physicians to or keep physicians in areas without hospitals. Finally, rural hospitals are often the major employers in their communities.

Data from the American Hospital Association paint a bleak picture of the condition of small rural hospitals. The complete data, available at this time only for 1984 and prior years, reveal sharp declines in small rural hospital operating margins. Hospitals with fewer than 25 beds showed a negative 7 percent operating margin for the first ten months of 1984. Hospitals with 25 to 49 beds showed a positive 5 percent margin, down 23 percent from the same period in 1983. Total patient days in hospitals with fewer than 50 beds dropped more than 19 percent in the first ten months of 1984, compared with the same period in 1983. Admissions dropped nearly 9 percent, while the average length of stay dropped from 5.4 to 4.6 days.

While the admissions to all U.S. hospitals dropped two percent from 1980 through 1984, admissions to rural hospitals dropped 17 percent. Approximately 60 percent of small and rural hospitals experienced net patient revenue operating margin deficits over this period.

The American Hospital Association's recently completed survey of 1985 trends indicates that the picture may be growing even bleaker for small rural hospitals. Admissions are continuing to decline, as are patient revenue net operating margins.

The Medicare prospective payment system is contributing to this distress because it inequitably under-reimburses many rural hospitals and because it fails to recognize the unique circumstances of small rural hospitals.

Ideally, how a hospital fares in a competitive health care delivery system and under a prospective payment system depends upon its ability to offer high-quality, cost-effective, needed health care services. The reality for rural hospitals under the Medicare prospective payment system is quite different. They are seriously disadvantaged.

The prospective payment system is a numbers game. Hospitals are expected to balance losses on some DRG cases with profits on others. Rural hospitals have fewer total admissions and a higher percentage of Medicare patients. Thus, they are particularly dependent upon Medicare revenues and do not have the number of admissions to effectively balance losses against profits. Substantial losses on one or two DRG cases may seriously jeopardize the viability of a hospital.

The rural/urban differentials in the prospective payment system result in the under-reimbursement of many rural hospitals and place them at a severe competitive disadvantage with suburban and many urban hospitals. In Iowa, for example, the federal payment for labor costs is approximately 23 percent greater for urban than for rural hospitals, and the non-labor differential is a staggering 54 percent. While labor and non-labor costs may be somewhat lower in the rural areas of my state, they are not 23 and 54 percent lower. Something is seriously wrong with a system which gives us differentials of this magnitude.

The Health Care Financing Administration argues otherwise, pointing out that the federal standardized rates are based on hospital cost reports. If that is in fact the case, then we may well have put in place a system which rewards hospitals with historically high costs and penalizes those which have historically held down their costs, which is precisely what we sought to avoid doing in creating the prospective payment system.

The way in which the federal rates are established for urban and rural reimbursement also disadvantages rural hospitals. The urban rates are an average of hospital cost report data for hospitals within standard metropolitan statistical areas. The rural rates, on the other hand, are an average of reported costs for rural hospitals across the state. Thus, the urban rates are much more reflective of the experience of particular urban hospitals. Much more deviation from the average occurs for particular rural hospitals.

Perhaps nowhere is the very crude and inequitable nature of the Medicare prospective payment system's use of geographic location as the basis of hospital reimbursement more evident than in the situation of rural hospitals located near urban areas. These hospitals are generally competing for staff in the same labor markets and paying comparable or in some cases higher salaries to attract and retain staff. These hospitals experience comparable non-labor costs. Yet they are reimbursed substantially less simply because they happen to fall outside the border of a Standard Metropolitan Statistical Area.

I have introduced legislation which will correct this inequity. This measure, H.R. 3767, which now has 44 Republican and Democratic cosponsors, allows rural hospitals within 75 miles of an urban area to file with the Secretary of Health and Human Services for an increase in reimbursement reflecting their actual labor and/or non-labor costs. To be eligible for a reimbursement increase, the rural hospital must demonstrate that (1) its costs are comparable to the costs of hospitals in the nearest urban area and its Medicare reimbursement fails to reflect these costs; (2) its average Medicare payment is less than 85 percent of what it would receive if it were located in the nearest urban area; and (3) the reimbursement differential is greater now than it was prior to the implementation of the prospective payment system. H.R. 3767 also establishes an appeals board to which hospitals may appeal denials of reimbursement increases.

I am pleased to report that Senator Grassley introduced this legislation yesterday to correct one of the most serious inequities in the prospective payment system's treatment of rural hospitals.

Yesterday, Senators Chuck Grassley and Max Baucus and Congressmen Ike Skelton, Jim Jones, Wes Watkins, Beau Boulter, and I introduced a more comprehensive bill to ensure that rural hospitals will no longer be treated inequitably and their unique characteristics and needs ignored as health care policies and regulations are implemented. Specifically, this legislation:

(1) Requires the Department of Health and Human Services to analyze the impact of proposed and final regulations on small rural hospitals and publish the analysis in the Federal Register at the time the proposed and final regulations are published.

(2) Retains the current law for capital cost reimbursement for sole community providers until the impact of any capital cost reform which may be adopted by Congress is clear.

(3) Requires the Department of Health and Human Services to develop standards to ensure that rural hospitals are receiving more adequate payment for unusually high cost cases (outliers).

(4) Sets aside 10 percent of research and demonstration funds for research and demonstrations on rural health care concerns.

(5) Requires timely payments to rural hospitals, which are particularly dependent on Medicare revenues.

(6) Establishes an Office of Rural Health Care within the Health Care Financing Administration.

The Prospective Payment Assessment Commission, an independent body of experts established by Congress to monitor the prospective payment system and make yearly recommendations for changes, recently issued its 1986 report. The report underscores the need to recognize the unique characteristics of rural hospitals in health care policymaking and to adjust the prospective payment system to ensure more equitable reimbursement for these hospitals if they are to remain viable. Let me share with you several key passages from this report:

> In particular, the financial vulnerability of small rural hospitals to fluctuations in volume and case mix has caused concern. For larger institutions, minor fluctuations in volume and case mix are less critical. Larger hospitals can average these fluctuations from year to year and over a large number of cases. Small rural hospitals cannot take advantage of this "law of of large numbers." If such hospitals are located in relatively isolated areas, and a deteriorating financial position results in closure of the facility, Medicare patients' access to services may be severely compromised...
>
> In the end, the Congress or the Secretary or both may have to determine whether it is appropriate to pay slightly more money or pay differently to avoid insolvency among certain rural hospitals...It may be cost-effective for Medicare to pay slightly more or slightly differently for care in these hospitals...if, by doing so, rural patients are not required to seek care in distant urban hospitals where the care is less accessible and more costly.

The Commission notes that Congress was aware that the prospective payment system could pose problems for rural hospitals and strongly urges the Department of Health and Human Services to complete and issue the reports on rural hospital issues that Congress has mandated to provide the basis for refinements of the system.

I urge you, Mr. Chairman and Committee Members, to join me in pressing for these reports and in enacting refinements in the prospective payment system to ensure that we are equitably reimbursing rural hospitals. Rural hospitals have been the stepchildren in health care policymaking for too long, now. We must give them a strong voice in this Congress or run the risk of the deterioration of the fabric of rural health care services in this nation.

Thank you for your attention to my testimony.

Senator DURENBERGER. Max, do you have an opening statement?

Senator BAUCUS. Yes, I do. Mr. Chairman, first I want to thank you for these hearings; I think these hearings today are criticial. They are very important, basically because, hearings today address a component of national health care policy which has been long neglecte; that is the demise of small rural hospitals.

In fact, small rural hospitals are on the critical list. Their vital signs are also weakening. According to the report prepared for today's hearing by the Congressional Research Service, 80 percent of the hospitals that closed last year were small and 43 percent were located in rural communities.

That study also shows that in the future the hospitals that are most likely to close are small and rural. Today nearly 70 percent of the rural hospitals with under 50 beds are unable to cover their costs with revenues from patients.

Unfortunately, when these hospitals have losses they have to turn to their communities for outside support to survive. Many of these same communities today, are also struggling themselves to survive, particularly due to the economic crisis facing rural America today. They may not be able to bail out these hospitals any longer.

Without rural hospitals, patient care suffers. The communities suffer by lost employment. People move out, they leave those towns. New residences and new businesses also have no reason to move into those communities.

Medicare suffers as well, if patients are forced to seek care in more distant and more costly urban areas. In some cases, especially in States like Montana and other nearby States, there may be no other hospital nearby to take their place.

When we started down the road of prospective payment, we all knew that some hospitals would have to close. After all that is the theory of the PPS system. The critical question is, What happens when the wrong hospital closes, the remote hospital that serves the entire region? The hospital that is critical to basic access to care for the entire population. What happens to the elderly with the highest users of health care, who disproportionately live in rural America, who are less mobile, and whose health care needs are more acute, more immediate. The sad fact is we do not have an answer yet, to that question.

Competition will not solve it and well-meaning rhetoric will not solve it. Rather we have to get our heads together and solve it ourselves.

Earlier this week, Senator Grassley, I, and others introduced the Rural Health Care Improvement Act. Basically, that legislation has two objectives: First it requires HHS to pay more attention to rural health care in several ways. By requiring the rural impact test on Medicare and Medicaid regulations before they are issued. By mandating that 10 percent of research funds be used for rural health issues. And, by establishing a rural health office within HCFA. Second, the bill provides for fairer payments to small rural hospitals.

One, by paying Medicare bills on time, without delay, on time. By paying hospitals a fair amount for their extremely high costs, that is outlier cases. And, by maintaining predictable, stable payments for the capital expenses of sole community providers.

We think this legislation is a solid first step. It is not a guarantee that rural hospital will not close, but it brings them more into the central debate that is going on in this town about the future of rural health care.

It is also high time that both the Congress and the administration begin to pay attention to these problems.

Mr. Chairman, I hope that today's witnesses let us know if this bill can be improved or if further measures are needed. I also hope to hear, whether today's witnesses believe that all small rural hospitals belong in PPS in the first place or whether the Sole Community Provider Program is working as planned.

Together we can work to insure that access to quality care is a reality for all Americans. Thank you.

Senator DURENBERGER. Max, thank you. I was reminded today by Dr. Sterling Hayward, how long you and I have been at this issue of health care delivery in rural America, because he recalled for me in 1981, that we held a hearing in Billings on this subject and that was before anyone knew what a DRG was or PPS. Probably very few people had a feeling for the dimension for the problem, but you did. That is why I was in Montana with you, and that is why we are having this hearing today. So, I very much appreciate that. George Mitchell.

Senator MITCHELL. Thank you very much, Mr. Chairman. I am pleased to participate in the hearing. I commend you for holding the hearing and commend you and Senator Baucus for the leadership you have shown in this important area.

Those of us on this subcommittee, who represent rural States are well aware of the problems which have arisen, particularly since the implementation of the prospective payment system in 1983. While we have evidence of dramatic reductions in length of stay in hospitalization under the DRG system, they are also aware of the strain the system has placed on small rural hospitals in our States and across the country.

This involves a lot of people and a lot of hospitals. Thirty-four percent of the community hospitals in New England are rural hospitals, nationwide the figure is nearly 47 percent. While the DRG system has been successful in reducing hospital costs nationwide, it has proven to be insensitive to conditions of life in rural areas. We must not forget those rural hospitals which often provide the only acute care available in large geographic areas.

Can we afford to have such hospitals driven out of business as a result of prospective system or other factors.

What will be the consequences to the elderly in rural America as Senator Baucus said and disproportionately represented there, if we allow this to happen. It is clearly our responsibility to help control the costs of the Medicare Program and the rising medical costs, generally.

It is equally our responsibility to protect the quality of care for the elderly and all Americans living in rural areas. It seems to me we must examine innovative approaches to health care in rural hospitals, including alternative ways of providing both acute and nonacute care in those hospitals, which can make better use of existing facilities and help the rural hospitals survive under the prospective payment system.

I commend Senator Baucus and Senator Grassley for their legislation and look forward to working on that and receiving the testimony here today. I hope this commmittee can work the health care community and rural States and to improve the condition of rural health care under the Medicare programs. Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you very much. Our next witness will be Bart Fleming the Acting Deputy Administrator for Health Care Financing Administration.

Bart, we thank you for being here today. I presume we have your statement and it will be made part of the record.

STATEMENT OF BARTLETT S. FLEMING, ACTING DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Mr. FLEMING. Thank you very much, Mr. Chairman. Let me just read a brief summary of that statement and as you said the entire statement has been submitted and I trust will appear in the record. Before I do that, let me introduce the gentlemen who are with me. On my right is Mr. Robert Streimer, Director of the Bureau of Eligibility, Reimbursement, and Coverage, and Mr. Al Dobson, on my left, is Director of the Office of Research.

I am pleased to be here today to discuss the health of rural hospitals and report on our activities in assuring continued access to quality care in rural areas. After over 2 years experience with the prospective payment system, evidence indicates that the system is working and hospitals are reaping the benefits of careful utilization of resources.

Both urban and rural hospital stays have declined significantly. In addition, several recent studies have reported that a large majority of both urban and rural hospitals show positive profit margins under PPS. In spite of this positive outlook, though, we are aware of concerns about rural health resources. These stem we think, in part from the more limited ability to implement necessary efficiencies under PPS because of rival hospitals smaller size, scope of services and lower occupancy rates.

We want to be responsive to PPS payment problems, but we believe that we must first identify the exact nature and magnitude of the problems before changes are considered to assist rural hospitals.

The major studies that we have underway will use recently available cost data, which are more reliable than those used in earlier studies, and will put us in a better position to determine if refinements in payments to rural hospitals are in fact appropriate.

Provisions Congress enacted in current law, such as separate payment rates for hospitals in rural areas, were designated to reflect the variations in circumstances and costs between urban and rural hospitals. In addition, under other statutory provisions, rural hospitals can qualify as sole community providers or rural referral centers and receive adjustments to their PPS payments.

To date, 359 hospitals have qualified as sole community providers and 7 of these have applied for additional payments permitted to reflect decreased admissions. One hundred and sixty-six hospitals have qualified as rural referral centers and are being paid using the urban payment rate.

We have also seen a significant increase since the implementation of prospective payment in the number of hospitals which elect to swing beds from an acute level to a skilled level as patient needs fluctuate. This allows hospitals to maintain higher occupancy levels, generating revenues from beds that would otherwise remain empty, and provides a broader access to skilled care for Medicare beneficiaries in rural areas, where there is a shortage of such care.

To date 771 hospitals are participating in the swing bed program, including 56 in Minnesota, 31 in Montana, and 18 in Oklahoma. I would also like to mention that rural health clinics, although not hospitals, also broaden access to primary health care services in rural communities. In 1985, almost $6 million was reimbursed to 428 such rural health clinics.

Hospitals which change classification because of redesignation from an urban area to an rural area are also provided adjustments to their prospective payments for 2 years to ease the impact of lower payments. We are now making adjusted payments to 51 hospitals in 49 counties that were redesignated as rural.

We are also implementing the recently enacted payment adjustment for rural hospitals which serve a disproportionate share of low-income and Medicare beneficiaries. They will receive a 4-percent increase in their payment rates for discharges on or after May 1. While we make these payment adjustments, we continue our studies to better define hospital labor market areas and identify disproportionate share hospitals.

We are also conducting several other major studies dealing with rural issues. We have recently completed a study required by the PPS legislation on equitable methods of paying sole community providers. The study addresses such issues as differences in case mix, changing the payment blend, and modifying payment adjustments for decreased utilization. That report is currently under review in the Department.

We have almost completed a single report on several separately mandated studies on interrelated urban-rural issues. The report will address such issues as phasing out separate urban and rural rates including a regional rate component, variation in the labor and nonlabor portions of the rate and payments for outliers.

We are also making plans for studies mandated by the recently enacted, Consolidated Omnibus Budget Reconciliation Act of 1985, that address the impact of PPS policies regarding outliers and patient transfer on payments to rural hospitals.

We recognize that the dramatic changes over the last several years in the health care industry have had a significant impact on all providers, not the least of which are rural providers.

We are monitoring the impact of PPS and examining areas of possible refinement. However, it is important for me to emphasize we are philosophically skeptical about the ability of a pricing regulatory system to cure all of the ills hospitals are now encountering. Instead, we believe we need to look to new ways of providing necessary health care, such as capitation—reliance on competitive incentives to assure appropriate utilization and quality of care.

In the meantime, I assure you, Mr. Chairman and members of this committee, we have no intention of endangering the accessibility of necessary health care for our beneficiaries in rural areas. We will actively continue our efforts to ensure that appropriate and equitable payment is made to both urban and rural hospitals.

And just let me conclude by saying that we are here today to learn along with you. We are anxious to hear what the other witnesses have to say. We believe, as I said in my opening remarks, that it is important for us to understand the definition of the problem and get at the causes before we jump right into a specific solution. So, we are interested here today to find out what the views of disparate interests in the health community are. Your colleagues from the House have already testified, and as I said, we are here to learn and take notes carefully.

Senator DURENBERGER. Well, I thank you for your statement. I thank you particularly for the tone of the statement. I think it is a little difficult—first, let me say on a positive sense, HCFA has done a very good job of coming in here every time we have a hearing and taking a lot of crap, from all of us. [Laughter.]

That is because we do not have anybody else to yell at. For so long a period of time the Department of HHS and its so-called policy side, which normally you would expect to be giving general policy guidance within which policy implementation guidance within which we would operate. They would operate within ours, I guess that is the way it is supposed to work. I have become so used to it going the other way around. It has really been very difficult to get a concensus on the problem and then get some action on it. I do not know when the last time I had the sense that in this administration at HHS there was a sense of policy where somebody could have a feel about rural America as something other than statistical.

And, so I want to begin by saying that HCFA has had a difficult job to do. I appreciate the tone of your response here which is that you are open. I appreciate the difficulty of coming to grips with some of the questions that have been raised, but I think you will note from those of us here a real sense of impatience about getting on with the job of suiting health policy in this new environment and the PPS system and everything else. To some realities that have existed for a number of years and realities that could have been predicted. I said earlier, Max and I were out in Montana in 1981 dealing with many of these same problems. The only difference is now we have a PPS process to work with.

The main problem, the problems of access to health care, were there in 1981. Yet, it has been very, very difficult to get any sensitivity to how Medicare, Medicaid, and other Federal policies ought to relate to that.

One of the problems that I know you have to deal with, you referred to earlier in your statement, which was the cost data problem. We had the HHS inspector general in here in February, I think, some time. It was on a report on hospital profits and it got attention all over the country. All these hospitals are making lots of profits that we did not think they were making. And, then if you did not read the story too deeply, it looked as though we were overpaying in the prospective payment system. We are giving them, these hospitals, too much money.

The reality is, I suppose, there were a lot of hospital profits on Medicare patients. But, compared to where Medicare was reimbursing earlier, I suspect the profits have somewhat slimmed down. If we only had, sort of accurate data on which to measure that analysis.

Now, I met with the IG people yesterday with the regard to Minnesota, because Minnesota happened to be one of the demonstration States. It is quite clear that one of their frustrations in trying to bring us up to date in 1986 is that their report was based on 1983 data, which obviously is somewhat difficult to project into 1986.

Now, to what degree do you have problems—or do we, with this whole business of having accurate costs data in which to premise some of our judgment.

Mr. FLEMING. Mr. Chairman, I know that is an important question and we have discussed [it], staff to staff a number of times that we do have accurate cost data. The problem is not whether or not we have adequate or accurate cost data, the problem has been one of timing. Let's just stop for a minute to look at when the cost data comes into the Agency. The Prospective Payment System became effective in 1983. The hospital's reporting period began at the start of its fiscal year and some of those hospitals' fiscal years did not begin until the following July. This meant that their reporting year was not complete until July of 1985. So, then we had to wait 90 days before their cost reports came in, and then go through the audit procedure. We really did not get completed 1983 cost data until just about a year ago.

Now, we are trying to simplify that process by using a sample of roughly 1,200 hospitals to first do an audit of their cost reports and then project on the as submitted reports of hospitals that deviation off of the cost reports that are submitted by the universe of hospitals. We hope that will speed things up and give us the ability to respond a little bit more quickly.

Senator DURENBERGER. One of the problems that I think each of us alluded to earlier was the problems of outlier policy. During the course of the rest of the morning, we are going to hear complaints about outlier policy. People arguing that the criteria used to qualify for outlier payments are much to restrictive and I think you know the problem of most rural hospitals, the really difficult cases, the ones that pay well under the DRG system, are not going to the rural hospitals. They are going into the much more expensive tertiary care hospitals in large cities, where gaming programs and things like that are attracting a whole lot of patients. They are not getting the cases that can make the money, yes, in effect, those are going into the cities.

By the same token, every once in awhile they're going to get a very, very expensive patient, expensive to care for, and all it takes in some small hospitals is one of those to break the back at least for that year of the hospital. Then that get's loaded onto the community and its tax base and you have all those kinds of problems.

Where are we now on that topic. Have I exaggerated the nature of the problem of outlier?

Mr. **Fleming**. It is a concern we have and while we are looking at that I am going to ask Al Dobson, from our office of research, to talk about outliers.

Mr. **Dobson**. We are looking at outliers across the board, not only at rural hospitals, but urban hospitals as well. I think that the problem with outliers is even more difficult than it appears at first, because of the way we calculated budget neutrality with respect to outliers.

We took away the same amount, 5 percent from all hospitals, and we paid back differentially urban to rural. And, because urban hospitals tend to have a larger percentage of outliers, we tend to give back a bit more money to urban hospitals at the expense of the rural hospitals.

What we probably ought to do, at least, is think about the way we do our calculation of budget neutrality or the way we take the outlier money out before we pay it back. If, we could get to where we take from the rurals and we give back to the rurals proportionately, then I think we would have a better outlier payment system. We are devoting a great deal of thought as to how that might be done, so there would be more equity. That is how to take out and give back the same proportion, as opposed to taking out disproportionately of the rurals and maybe giving a little bit of a subsidy over to the urban hospitals.

Mr. **Fleming**. There is a lot of work that can be done there.

Senator **Durenberger**. Well, is there some prospect within some near term that we are going to see some change in that realm.

Mr. **Dobson**. Well, I think what we have to do is get the cost data that Mr. Fleming just mentioned and make sure that our early speculations on this are right. And, after we get the cost data, as we move through the summer and get out of this regulatory process, I think we will be able to discuss this much more accurately. And, our speculations will be better founded than they are at this point.

Senator **Durenberger**. One of the—I do not have a specific question that sites the facts of this, but I have just noticed lately that a lot of people are complaining about the deliberate policy on the part of the Government to pay late on Medicare claims. What I have read in the newspapers, sort of looks like the Government, whatever that is, acknowledges it is a deliberate policy, that we pay late like everybody else does. We make a little money on the side—now that is again a particular problem for small hospitals and a particular problem for rural hospitals.

To what degree is that the payment policy in HHS and why?

Mr. **Fleming**. What we have committed to do—consistent with our resources—is to move to a payment schedule that more closely approximates the guidelines of the Prompt Payment Act. Now, Medicare is not restricted by the Prompt Payment Act, but that Act was passed by Congress to set some guidelines for the rate at which Government would pay its bills. Generally, industry is operating on a 30-day cycle. We do not think that is an unreasonable cycle and we do not want to stretch it beyond that. But, it is gradually moving to roughly a 30-day payment cycle.

Senator DURENBERGER. Max.

Senator BAUCUS. Mr. Fleming, there have been several studies that generally address the differences between urban and rural hospitals, that Congress has asked of HCFA, which are overdue. Where are they?

Mr. FLEMING. Senator, we are in the process of putting together the cost report data on which those reports need to be based in order for us to give you an accurate reflection as to what has happened. Had we completed those reports earlier, they would have been based on cost data that did not reflect prospective payment, and we feel it is important to look at what has happened in the behavior and the costs of hospitals since prospective payment has been passed.

Senator BAUCUS. Let me just tell you what those reports are. In 1983, under the Social Security Act Amendments, you were asked to study the impact of eliminating separate urban and rural PPS rates and that was due at the end of last year. Also, in the 1983 Social Security Act Amendments, you were asked to study fair reimbursement for sole community providers; that was due on April 1, 1985. In 1984, the reconciliation bill asked for the appropriateness of urban and rural differential payments for DRG's with high technology and low labor costs. That was also due the end of last year.

When Mr. Neuman came before this committee, sitting in the exact same spot where you are now sitting, he promised that, if anything, his sole goal was to get reports in on time. He prided himself on that. Here it is, mid-May practically, and some of these reports are way overdue. When are we going to get them?

Mr. FLEMING. Senator, the Department is making a very concerted effort to move a number of the reports that are overdue, not just those due from HFCA, but other agencies in the Department as well.

Senator BAUCUS. I do not mean to be difficult, Mr. Fleming. I know you are making an effort. I give you the benefit of the doubt by saying you are making an effort, but my question was, when?

Mr. FLEMING. Senator, when we are able to complete and use the cost data that is compiled from the 1984 cost reports, we will be able to complete those reports. I would hope fall to winter.

Senator BAUCUS. Is it HCFA's policy to just do whatever HCFA wants and pay no attention to or completely disregard the law. The law says those reports are due by a certain date and I can understand that if in the judgment of HCFA, perhaps information is not fully available, but the law is the law. And, is it HCFA's policy to disregard the law and for HCFA just to willy-nilly do whatever HCFA wants to do despite the law.

Mr. FLEMING. Senator, certainly not——

Senator BAUCUS. That seems to be the case, your answer seems to suggest that.

Mr. FLEMING. Our interest is in getting to the Senate the very best report possible, so that you can make the very best decision possible.

Senator BAUCUS. Should not that be the judgment of the Congress, if the Congress makes legislation to have a report due by a certain date? Should not that be the judgment by the Congress, whether the data is sufficient or insufficient? Is not that the judgment of the Congress? Not for HCFA willy-nilly to do whatever HCFA wants to do, thumb its nose at the Congress and say we do not care what you have enacted in law; we are going to do what we want to do. That is what it sounds like.

Mr. **FLEMING**. Well, first of all, Senator, I do not believe that HCFA or the Department has thumbed its nose at Congress. We have spent a lot of time working with the staff of this subcommittee and individual Members of the House and Senate to work out differences and problems in a wide variety of issues that surface.

Senator **BAUCUS**. I raise this—basically, because your whole statement has said we are studying this, and we are studying that. I wish I had a dollar for the number of times you mentioned the word "study" in your statement. It is particularly surprising to me that you mentioned study without reference to the studies that Congress has previously asked for and mandated and which were due months ago, in one case, 1 year ago. And, yet, you just blithely, go about everything and just talk about studies. And, in your statement you did not give any indication as to when these studies you are talking about are going to be submitted to the Congress. So, if you could just tell me when your studies are going to be completed.

Mr. **FLEMING**. Senator, I understand your concern. I believe my statement did refer specifically to the studies. The cost data is in, and we will look to having those reports to this body as I said, fall or winter. We want to do a good job.

Senator **BAUCUS**. Which?

Mr. **FLEMING**. Winter. [Laughter.]

Senator **BAUCUS**. What year? [Laughter.]

Mr. **FLEMING**. We will try to do it in the year of 1986, sir.

Senator **BAUCUS**. Winter of 1986.

Mr. **FLEMING**. Yes, sir.

Senator **BAUCUS**. Second question.

Mr. **FLEMING**. We went through this a couple of weeks ago, remember?

Senator **BAUCUS**. Yes, we did.

Senator **DURENBERGER**. Remember Henry DesMarias' wife was going to have a baby and you predicted that the physician payment report would get out before the baby. The baby is here, the report is not.

Senator **BAUCUS**. That is right, Mr. Chairman, at that point I made a remark that there is a vast difference between Mother Nature and human nature.

Senator **DURENBERGER**. I will call that. [Laughter.]

Senator **BAUCUS**. You can predict Mother Nature, but you cannot predict human nature.

Mr. Fleming, the core of the problem seems to me to be this: the PPS system is based upon the premise that efficient hospitals will thrive, prosper and that inefficient hospitals will not. That is the basic premise of the PPS. Now, there is an unarticulated premise that an inefficient hospital under PPS will not stay in business. Doors will have to close and the patients that live in that community can go to a nearby more efficient hospital, that is open.

Now, the problem is that in rural America there often is no other nearby efficient hospital, if an inefficient one closes. The question is, What are we going to do in those cases? Who has the responsibility? Should the Federal Government have the responsibility for those patients, people that live in those communities, where there is no nearby efficient hospital?

Now, you well know that this country is diverse. Eastern United States, coastal areas are much more populated, they are much more dense. Rural America, interior America, Rocky Mountain States, and many parts of other States, are not densely populated. There are vast distances between communities and most communities are very small.

So, what do you think our policies should be in those cases, that is where people do not have any place to go to? There is no efficient hospital they can go to.

Mr. FLEMING. Senator, I come from such a State—Arizona, with a widely dispersed population, two major population centers—and have been an elected office in that State and have served on a board of a hospital in Phoenix. So, I am not unfamiliar with those concerns.

To go back to your opening remarks on this question, yes, the PPS is based on a premise that efficient hospitals will do well, less efficient hospitals will not do as well. But, there is another premise, that is perhaps implicit and that is that inefficient hospitals will work to become efficient. We realize that rural hospitals work under a considerably different set of constraints than do the urban hospitals.

We do not assume inefficiently operated hospitals will close. We suspect that that may happen, but we did not set out intentionally to see that some hospitals close down. What we set out to do was to change the incentives, so that hospital administrators and all those who were responsible for administering care in a hospital would have a different set of incentives to motivate their behavior, and of course we have seen that take place.

We recognized that there would be some hospitals that would not be able to make those adjustments and perhaps make some other changes. We provided some options for them. In fact, prior to PPS, the swing bed program was implemented and a number of rural hospitals have taken advantage of that.

We established the sole community hospitals and the rural referral centers and built in some cushion to absorb some of this shock for them. In spite of that, there are still some hospitals that we understand are having troubles. We want to be sensitive to those needs, but the core of your question really is a philosphical one and ~~that is~~, whose responsibility is it should that one hospital, I believe you phrased it, in your opening remarks, the wrong——

Senator BAUCUS. While you are answering the question, it is important to bring another component. The small rural hospitals are operating under a severe disadvantage compared with urban for various reasons: No. 1, they have a much higher fixed costs proportionate to their revenue, much higher. And, when HCFA comes up with regulations, which tend to pose a cost upon all hospitals, there often is a disproportionate burden placed on small rural hospitals. Second, revenues are declining everywhere in all hospitals and particularly declining in rural hospitals, particularly again, where the agricultural crisis and economic crisis is facing the rural America.

In addition, there are tremendous payments to urban hospitals, that rural hospitals do not receive. For example, there is the two-tier system, which in many cases pays much more, up to 30-percent higher payments to urban hospitals compared with payments for the same DRG's to small rural hospitals. On top of that, teaching hospitals get an additional amount, about an 8½-percent payment, which obviously by definition small rural hospitals do not get.

Furthermore, there is the disproportionate share provision in the law, based upon the number of elderly that are in a community. It turns out that again, only about 50 rural hospitals received this share.

Reason upon reason, why urban hospitals get more payment, they are helped more compared with rural hospitals. So, again, I ask the question, whose responsibility is it, when some of the rural hospitals, through no fault of their own—partly due to payment policies, partly due to economic and demographic trends, partly due to just the lack of the law of large numbers, which urban hospitals can benefit from and rural cannot—are forced to close. As you well know, the communities, the people, the town fathers in these small communities are making up the difference. They want their hospital to stay open. And, they are scrapping, they are scraping, they are doing everything they can to come up with additional funds to basically keep their hospitals open, which is not the case in urban America.

Mr. FLEMING. That is correct.

Senator BAUCUS. Is it fair, I ask you, when the net result of all these policies, folks in small towns, small communities, have to pay—come up with extra funds somewhere just to keep the hospitals open, where that is not the case in urban America.

Mr. FLEMING. That is basically, a philosophical question.

Senator BAUCUS. It is also a very practical question.

Mr. FLEMING. Yes, it is a very practical question.

Senator BAUCUS. It is a very practical question for those folks who live in those communities and those senior citizens and those elderly, who are deprived of commensurate health care.

Mr. FLEMING. I am very reluctant to say that it is a responsibility of the Federal government to maintain individual hospitals in rural communities. The Medicare Program was established to provide acute care to its beneficiaries. That is our desire, and we work very hard to ensure that our beneficiaries are well taken care of——

Senator BAUCUS. Is it the responsibility of the Federal Government or a HCFA to address this problem.

Mr. FLEMING. It is and we do want to address it. We want to address it when we understand the problem and the cause of the problem, so we can come up with and supply this body the proper solution.

Senator BAUCUS. Are you saying you do not understand the problem?

Mr. FLEMING. What we want to understand is the definition of the problem precisely. To what degree is there is a problem. And, under what circumstances does the problem exist.

Senator BAUCUS. Well, I hear what you are saying, Mr. Fleming, and I must tell you I am not fully satisfied that we are going to see much action here. But, what I am telling you here, there is going to be a change. And, I just hope that you come along willingly, rather than unwillingly. Because if you come along unwillingly, it is going to cause a lot of problems for you and a lot of other folks. So, I encourage you to act very quickly.

Mr. **Fleming**. I assure you that we will work with you, this committee and your chairman.

Senator **Durenberger**. George Mitchell.

Senator **Mitchell**. Thank you very much, Mr. Chairman. I would like to focus on one of the factors that, which Senator Baucus and others have referred to, that is the wage differential. In Maine the—one of the largest cities is Bangor and it has a major hospital, Eastern Maine Medical Center. Less than 30 miles away is the town of Ellsworth, where there is also a hospital. The hospital in Bangor you find is urban, the one in Ellsworth is rural and therefore, they actually, and in fact compete for personnel directly, one is reimbursed at urban rate and one at the rural rate. I have a series of questions on this same subject, so that I have asked them all and then ask you to deal with them in a single response.

Are you aware as to whether or not this situation occurs often. It seems to be most inevitably for given the urban-rural definition in your opinion is there really a significant different wages, which those in rural areas are expected to be paid as compared to those in urban areas, particularly where there are as in this case, just a few miles apart and effectively live within the same region? and, in your opinion is it fair to reimburse rural hospitals at a lower rate based upon the expectation that if a hospital is in a rural area its labor costs must inevitably be lower than hospitals in an urban area.

Mr. **Fleming**. We will try to address all three of those questions. I am going to ask Mr. Bob Streimer of the Bureau of Eligibility, Reimbursement and Coverage to begin.

Mr. **Streimer**. I think there are two dimensions that we need to focus on, Senator. One is the wage differential itself. That wage differential has been developed from actual wage and salary data from all the hospitals; so, it reflects the real experience. I think that the key issue comes up when you draw lines to separate urban and rural areas. No matter where you draw the line, you are going to have instances pop up where someone is close to the line or there are two hospitals that straddle the line.

The lines that have been drawn in the statute the Metropolitan Statistical areas. We are studying actively other ways of drawing those lines, perhaps with an eye toward changing the definition, using some other data base or perhaps modifying substantially the ways rural wage indexes are grouped together. Right now, they are grouped statewide. Maybe we should be looking at other ways of grouping the rural hospitals, but it is important to remember that the data from which the indexes are derived are directly from hospital wages and salaries.

Senator **Mitchell**. Are you familiar with the provision in the legislation that Representative Tauke talked about and that Senator Grassley has introduced that addresses this specific problem.

Mr. **Streimer**. No, I am not, sir.

Senator MITCHELL. Well, I would appreciate it if you would review that and provide the committee with your judgment on whether that provision would be at least one effective way to deal with that specific problem.

Now, in Maine, our experience is that, rural hospitals in several cases are experiencing declining occupancy rates. At the same time, in our State, almost in all areas and certainly in all rural areas, we have a shortage of long-term care facilities. Are there not any viable alternatives for utilizing empty beds in rural hospitals? Is the swing bed concept difficult to establish?

Our commissioner of human services in Maine is working on a—hopefully what will prove to be a workable reimbursement scheme, is this true in other States, is this occurring nationally. Are you doing anything to encourage it, participate in developing an effective reimbursement mechanism to encourage utilization of existing facilities that would permit these hospitals to survive and at the same time meet an existing need in a directly related health care area?

Mr. STREIMER. I think the popularity of the swing bed program is evident by the 771 hospitals that participate. The long-term care issue becomes very much of a Medicare-Medicaid issue also. Many of the State Medicaid programs have also adopted swing bed programs. Unfortunately, Maine is not one of the States that chose to do so. States also tend to control the number of beds that become nursing home beds through internal certificate of need processes, and many States have been reluctant to allow beds to be converted to nursing home beds because of their certificate of need laws.

Mr. FLEMING. Senator Mitchell. One of my colleagues would like to add one comment to one question on there.

Senator MITCHELL. Yes.

Mr. DOBSON. I think it is very important to realize when we talk about rural hospitals, we have to separate out prospective payment from other payers, from nonpayers. The payment levels that were set for prospective payment in rural areas were based upon the actual costs reflected in the 1982 cost reports. So, on the average across rural areas, the payments that we make for rural hospitals reflect the costs and the charge structures that rural hospitals had incurred historically. While there is a difference between the rural and the urban hospitals, that is a historical perspective and we are reflecting that.

Furthermore, when you look at the relationship between the revenues and costs of rural hospitals from a prospective payment point of view, it looks as if prospective payment is doing very well by most rural hospitals. We pay, on average, more than rural hospitals, costs as near as we can tell from 1984 data simulating the costs and revenue streams. It looks as if prospective payment is strengthening rural hospitals on average, not weakening them.

Senator MITCHELL. I think that is a matter of some dispute. I see my time is up, not only the majority leader has a very tight schedule, so I will be pleased to yield to him. I have several other questions I would like to submit them in writing and asked that they receive responses at your earliest opportunity, Mr. Leader.

Senator DOLE. In absence of the Chairman, I would ask him that my statement be made a part of the record and I want to complement the chairman, and also Senator Baucus for their continuing interest in this area. I have also been one of those who has been writing letters from time to time, asking: "Where is the report?" We hope to see it soon—it is long overdue. You say we might have the report in the winter of 1986?

Mr. FLEMING. This coming winter.

Senator DOLE. Christmas. But, if we are not here, be sure someone mails it to us. [Laughter.]

Are we going to be here, I do not know?

I also would like to make my statement a part of the record and certainly want to acknowledge the presence of my friend, Curtis Erickson, who holds the double distinction of being the president and chief executive officer of the Great Plains Health Alliance in Phillipsburg and also a newly appointed Commissioner of the Prospective Payment Assessment Commission, representing rural hospitals. I would ask that my statement be made part of the record.

Senator DURENBERGER. Without objection, it will.

Senator DOLE. I want to ask one question, we have a problem in western Kansas with respect to rural referral centers. I believe Mr. Erickson will make this problem clear in his statement. Basically, there have been a series of criteria constructed to determine eligibility of the hospital to receive the higher urban PPS rate. We have found, for example, that the requirement that you have a minimum of 6,000 discharges may be too restrictive. Can you tell me how this number is arrived at? I understand you are now looking at 3,000 number for osteopathic hospitals. Why the distinction and why not have some lower number? We meet five of the six, as I understand it, but we are eliminated because of this discharge requirement. Hadley Hospital is a very fine hospital.

Mr. FLEMING. Your question is on the criteria for determining the six.

Senator DOLE. Well, if you want to make it five out of six, you would qualify.

Mr. DOBSON. I cannot speak to the five out of six, but in general, the analyses we have done suggest that rural hospitals with a larger volume of discharges and larger numbers of beds have higher cost structures that more closely approximate urban hospital cost structures. And, the idea of having a threshhold, a relatively high threshhold, was that hospitals would be so identified that would more closely approximate the urban cost structures. As you recall, this provision allows the hospitals to have some proportion of the urban payments. We wanted to make sure when we put the provisions in place, that we were indeed paying hospitals that were more alike in the payment structure that we were providing them. Now, I cannot speak to the five out of six, but for that one issue, that is the logic behind the high threshhold.

Senator DOLE. We never required that it be perfect around here, but we always said if you meet 5 out of 6 or 4 out of 5 criteria, in our case we meet 1 of 10, then we are qualified. [Laughter.]

It seems to me you might want a little flexibility there and it is an issue that Mr. Erickson will touch on directly. Just one other question, because I know there are a number of witnesses. I think Senator Baucus was pointing out indirectly that, in addition to providing necessary health care, medical services, rural hospitals are also important to our economy in rural areas. While we recognize the limitations of the Federal Government, we are concerned.

We also are concerned that rural hospitals receive fair treatment under the prospective payment system. The Prospective Payment Assessment Commission has recommended using a discharge weight standardized payment amount to recognize the higher than average amount of care these institutions provide to Medicare beneficiaries. Could you please comment on the Department's thinking concerning this strategy?

Mr. STREIMER. It's something we are actively reviewing right now for purposes of preparing the June Notice of Proposed Rulemaking in which we will respond to all the Prospective Payment Assessment Commission recommendations. And, we expect that will be published on June 2.

Senator DURENBERGER. Do you want to comment on it in some way?

Mr. STREIMER. Well, I think it is still under active discussion in the Department.

Senator DURENBERGER. Are you prohibited by law from speaking about thinmgs that are under active consideration or something?

Mr. FLEMING. Senator, as far as I know, it has not even come up for discussion in any policy meeting. It is being discussed at a staff level right now in preparation of the regulation.

Senator DURENBERGER. Do you have any views? I think the leaders are trying to find out what is going on in your heads right now on the subject and June is next month, I think. [Laughter.]

Mr. FLEMING. Several weeks.

Senator DOLE. That is the day we start the tax bill, June 2.

Senator DURENBERGER. We will not have time.

Senator DOLE. We will obviously take a look at the report. I know the administration has a very difficult job and I think in many areas we seem to be critical on this side but there are a number of bright spots too, as you have indicated. However, when it comes to treatment of rural hospitals, we are certainly aware of the problems. As you must understand and do understand, we bring to your attention the areas that are causing concerns. You never hear about those without problems. So, thank you very much.

Mr. FLEMING. Thank you.

Senator DURENBERGER. Max, do you have any other questions?

Senator BAUCUS. Yes, a couple of questions, Mr. Chairman, thank you. Mr. Fleming, what is the savings or the costs of the delay in the payments under Medicare? What is the dollar amount, say to a 15-day differential?

Mr. FLEMING. To the trust fund, I believe over a year we are talking about $106 million, but let me submit the exact number for the record, but it is in the $100 to $200 million ballpark.

[The information of Mr. Fleming is to follow:]

For each day the payment cycle is increased, $1.8 million in contractor expenditures are avoided. A fifteen-day delay in payment would save $27 million in contractor funding annually. Each day of increase in the payment cycle also allows $8 million in interest to accrue to the trust funds. A fifteen-day increase would result in $120 million in interest added to the trust funds annually.

Senator **Baucus**. What I am trying to get at is, how much is Uncle Sam gaining by delaying of payments out of the trust fund, 15 days and commensurately, how much are hospitals losing because of a potential 15-day-on-average delay in receiving payment. I am just trying to figure out what—to determine what that amount is.

Mr. **Fleming**. To the trust fund, it is in the $100 to $200 million dollar range and I will get the figure for you.

Senator **Baucus**. $100 to $200 million.

Mr. **Fleming**. Yes, to the trust funds.

Senator **Baucus**. For every 15 days.

Mr. **Streimer**. Per year.

Mr. **Fleming**. Per year, for a year, now.

Senator **Baucus**. Now, what is per year.

Mr. **Fleming**. Well, when you expand the payment cycle by 15 days, the annualized effect of that is $100 to $200 million positive interest for the Trust Fund.

Senator **Baucus**. Does Uncle Sam have the capability to speed up payments? If HCFA wanted to speed up payments, could it?

Mr. **Fleming**. Do we have the physical ability or the knowledge to do it? Yes, we do.

Senator **Baucus**. Why is HCFA not doing it, then?

Mr. **Fleming**. The constraints that we have under Gramm-Rudman and trying to do our part in solving the Federal deficit, force us to make some economies in the various parts of the program, the administration of the program.

Senator **Baucus**. Do you think that is a proper way to make those economies? Is there a better way for HCFA to find some other savings rather than take it out of the hide of hospitals?

Mr. **Fleming**. Senator, I suspect if we found it some place else, this committee would simply be on us for that issue as well. So, we try to do it in the way that we feel is least damaging, that will let us continue to operate the program as efficiently as we can, to the benefit of our beneficiaries.

Senator **Baucus**. So, just that I get the record straight, what I hear you saying is that it is the policy of HCFA to delay payment in order to make up revenue for whatever reasons, Gramm-Rudman or otherwise. It is the policy to delay payment.

Mr. **Fleming**. It is the policy to go to a 30-day cycle, consistent we think with the guidelines set by the Congress in the Prompt Payment Act.

Senator **Baucus**. Now, what—how short could the payment cycle reasonably be, you say you intentionally delayed to go to 30 days. So, my question is, what is a reasonable period within which prompt payments could be made if you work hard at it? How many days would that be as opposed to 30?

Mr. **Fleming**. I really cannot answer, because I do not deal daily in the operations area of the program, but I will answer that for the record for you if you would like.

Senator **Baucus**. Mr. Roper was here, I asked him about capitation and other models of payment. And he said, yes, he is going to push HMO's and capitation systems, but he also said that it probably will not work in the rural areas.

Your statement was the opposite, or at least it said that we are pushing for capitation models and HMO's and so forth and that is not what Mr. Roper said.

Mr. **Fleming.** I have not read Dr. Roper's statement. We have chatted on this subject, because, obviously, we are concerned about the success of HMO's and the principle of capitation. HMO's are not the only way to capitate and it is probably true if he said HMO's will not work as well in a rural setting; I think I would probably agree with that. What I would say is that the capitation principle does not die because an HMO is not the vehicle. We have in a number of States groups of physicians that are looking at statewide provider organizations and their ability to provide statewide coverage in a capitated system. So, there are other capitation approaches other than just the HMO vehicle that may be applicable.

We think those are solutions that ought to be considered before jumping into a very hasty reaction to the perceived problem of the rural hospitals.

Senator **Baucus.** Do you have any comments you want share with us today, reactions to the bill that Senator Grassley and I introduced.

Mr. **Fleming.** We have just taken a very quick look at it. There has been no discussion on it as yet and I would rather reserve that until we have an administration position on the bill. Thank you.

Senator **Baucus.** Thank you, Mr. Chairman.

Senator **Durenberger.** Max, thank you.

Senator **Baucus.** Thank you very much.

Mr. **Fleming.** Mr. Chairman, I was——

Senator **Baucus.** You are a very busy man and I wonder if you are going to be here for this whole hearing? I would like Mr. Fleming to stay for this entire hearing. There are a lot of witnesses, who are going to come up and lot's of good testimony, it is a very important issue and I think it is important that Mr. Fleming, himself stay for the entire hearing as we both will, so that we all get the benefit of their testimony.

Mr. **Fleming.** I was planning on it.

Senator **Durenberger.** I am sure in the spirit of his opening statement he would be more than willing to do that, Mr. Dobson and Mr. Streimer might want to stay too. Fill three chairs on the front row, all of their assistants can leave. [Laughter.]

[Prepared statement of Barlett S. Fleming follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

BARLETT S. FLEMING

ACTING DEPUTY ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

MAY 9, 1986

SUMMARY STATEMENT OF BARTLETT S. FLEMING
ACTING DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION
MAY 9, 1986

I AM PLEASED TO BE HERE TODAY TO DISCUSS THE HEALTH OF RURAL HOSPITALS AND REPORT ON OUR ACTIVITIES IN ASSURING CONTINUED ACCESS TO QUALITY CARE IN RURAL AREAS. AFTER OVER TWO YEARS' EXPERIENCE UNDER THE PROSPECTIVE PAYMENT SYSTEM (PPS), EVIDENCE INDICATES THAT THE SYSTEM IS WORKING AND THAT HOSPITALS ARE REAPING THE BENEFITS OF CAREFUL UTILIZATION OF RESOURCES. FOR BOTH URBAN AND RURAL HOSPITALS, LENGTH OF STAY HAS DECLINED AND RECENT STUDIES HAVE REPORTED POSITIVE PROFIT MARGINS FOR A LARGE MAJORITY OF BOTH URBAN AND RURAL HOSPITALS UNDER THE PPS PROGRAM.

IN SPITE OF THIS POSITIVE OUTLOOK, WE ARE AWARE OF CONCERNS ABOUT RURAL HOSPITALS BECAUSE OF THEIR MORE LIMITED ABILITY TO IMPLEMENT NECESSARY EFFICIENCIES UNDER PPS, DUE TO THEIR SMALLER SIZE, SCOPE OF SERVICES AND LOWER OCCUPANCY RATES. WE WANT TO BE RESPONSIVE TO PPS PAYMENT PROBLEMS, BUT BELIEVE WE MUST FIRST IDENTIFY THE EXACT NATURE AND MAGNITUDE OF THE PROBLEMS BEFORE CHANGES ARE CONSIDERED. THE MAJOR STUDIES WE HAVE UNDERWAY WILL USE RECENTLY AVAILABLE, MORE RELIABLE COST DATA, AND WILL PUT US IN A BETTER POSITION TO CONSIDER WHETHER PAYMENT REFINEMENTS ARE APPROPRIATE.

PROVISIONS CONGRESS ENACTED IN CURRENT LAW, SUCH AS SEPARATE PAYMENT RATES FOR RURAL HOSPITALS, WERE DESIGNED TO REFLECT THE VARIATIONS IN CIRCUMSTANCES AND COSTS BETWEEN URBAN AND RURAL HOSPITALS. IN ADDITION, UNDER OTHER STATUTORY PROVISIONS, 359 RURAL HOSPITALS HAVE QUALIFIED AS SOLE COMMUNITY PROVIDERS AND 166 AS RURAL REFERRAL CENTERS TO RECEIVE ADJUSTMENTS IN THEIR PPS PAYMENTS. WE HAVE ALSO SEEN A SIGNIFICANT INCREASE SINCE THE IMPLEMENTATION OF PPS IN THE NUMBER OF HOSPITALS ELECTING TO "SWING" BEDS FROM AN ACUTE LEVEL OF CARE TO A SKILLED LEVEL AS PATIENT NEEDS FLUCTUATE. CURRENTLY, 771 HOSPITALS ARE PARTICIPATING IN THE SWING BED PROGRAM, INCLUDING 56 IN MINNESOTA, 31 IN MONTANA, AND 18 IN OKLAHOMA. I WOULD ALSO NOTE THAT MEDICARE PAYS OVER $6 MILLION TO 428 RURAL HEALTH CLINICS PROVIDING ACCESS TO PRIMARY HEALTH CARE SERVICES IN RURAL COMMUNITIES.

WE ARE ALSO MAKING ADJUSTED PAYMENTS TO 51 HOSPITALS IN 49 COUNTIES THAT WERE REDESIGNATED AS RURAL, AND ARE IMPLEMENTING THE RECENTLY ENACTED PAYMENT ADJUSTMENT FOR RURAL HOSPITALS WHICH SERVE A DISPROPORTIONATE SHARE OF LOW INCOME AND MEDICARE PATIENTS. WHILE WE MAKE THESE PAYMENT ADJUSTMENTS, WE CONTINUE OUR STUDIES TO BETTER DEFINE HOSPITAL LABOR MARKET AREAS AND IDENTIFY DISPROPORTIONATE SHARE HOSPITALS.

WE ARE ALSO CONDUCTING SEVERAL OTHER MAJOR STUDIES DEALING WITH RURAL ISSUES. WE HAVE RECENTLY COMPLETED A STUDY REQUIRED BY THE PPS LEGISLATION ON EQUITABLE METHODS OF PAYING SOLE COMMUNITY PROVIDERS. IN ADDITION, A SINGLE REPORT ON SEVERAL SEPARATELY MANDATED STUDIES ON INTERRELATED URBAN/RURAL ISSUES IS ALMOST COMPLETED. WE ARE ALSO MAKING PLANS FOR STUDIES MANDATED BY THE RECENTLY ENACTED RECONCILIATION ACT THAT ADDRESS THE IMPACT OF OUTLIER AND PATIENT TRANSFER POLICIES ON RURAL HOSPITAL PAYMENTS.

WE ARE MONITORING THE IMPACT OF THE PPS SYSTEM AND EXAMINING AREAS OF POSSIBLE PAYMENT REFINEMENT. HOWEVER, WE ARE PHILOSOPHICALLY SKEPTICAL ABOUT THE ABILITY OF A PRICE REGULATORY SYSTEM TO CURE ALL THE ILLS HOSPITALS ARE NOW ENCOUNTERING. INSTEAD, WE MUST LOOK TO NEW WAYS OF PROVIDING NECESSARY HEALTH CARE, SUCH AS HEALTH MAINTENANCE ORGANIZATIONS, THAT RELY ON COMPETITIVE INCENTIVES TO ASSURE APPROPRIATE UTILIZATION AND QUALITY. IN THE MEANTIME, WE WILL ACTIVELY CONTINUE OUR EFFORTS TO ASSURE APPROPRIATE AND EQUITABLE PAYMENT TO BOTH URBAN AND RURAL HOSPITALS.

I AM PLEASED TO BE HERE TODAY TO REPORT ON THE HEALTH OF RURAL HOSPITALS UNDER THE PROSPECTIVE PAYMENT SYSTEM (PPS) AND TO DISCUSS OUR ACTIVITIES IN ASSURING THE CONTINUED ACCESSIBILITY OF QUALITY HEALTH CARE IN RURAL AREAS.

TWO AND ONE-HALF YEARS INTO THE IMPLEMENTATION OF PPS, EVIDENCE INDICATES THAT THE SYSTEM IS SUCCESSFULLY PROVIDING A POSITIVE INCENTIVE FOR HOSPITALS TO CONTAIN COSTS WHILE MAINTAINING THE QUALITY OF CARE. INDUSTRY-WIDE COST INCREASES HAVE SLOWED AND HOSPITALS ARE REAPING THE BENEFITS OF CAREFUL UTILIZATION OF RESOURCES. ALTHOUGH DEFINITIVE DATA ON THE IMPACT OF PPS IS STILL BEING DEVELOPED FOR THE FIRST YEAR OF THE SYSTEM'S OPERATION, EARLY ESTIMATES INDICATE THAT HOSPITALS IN BOTH URBAN AND RURAL AREAS HAVE EXPERIENCED A GENERAL IMPROVEMENT IN THEIR FINANCIAL POSITION SINCE THE IMPLEMENTATION OF PPS. IN A RECENT STUDY, THE RAND CORPORATION DERIVED COST ESTIMATES BASED ON PPS AND PRE-PPS COST REPORTS AND SAMPLE CLAIMS DATA. IN APPLYING RAND'S WORK TO ALL PPS CLAIMS, THE PRELIMINARY RESULTS FOUND THAT A LARGE MAJORITY OF BOTH URBAN AND RURAL HOSPITALS SHOWED A POSITIVE MARGIN OVER THEIR COSTS FOR MEDICARE PATIENTS.

THIS IS IN LINE WITH OTHER STUDIES, INCLUDING THOSE PERFORMED BY THE DEPARTMENT'S INSPECTOR GENERAL AND THE AMERICAN HOSPITAL ASSOCIATION, WHICH ALSO SHOWED THAT HOSPITALS EXPERIENCED A POSITIVE PROFIT MARGIN DURING THE FIRST YEAR OF PPS IMPLEMENTATION.

OTHER INDICATORS DEMONSTRATE THAT PPS IS WORKING. FOR EXAMPLE, OUR DATA SHOW THAT BOTH URBAN AND RURAL HOSPITALS HAVE DEMONSTRATED A SIGNIFICANT DECLINE IN THE AVERAGE LENGTH OF STAY; CURRENTLY URBAN HOSPITALS ARE EXPERIENCING AN AVERAGE OF 8.2 DAYS AND RURAL HOSPITALS AVERAGE 6.7 DAYS. THIS HAS BEEN ACCOMPLISHED WITH NO EVIDENCE OF AN OVERALL DECLINE IN THE QUALITY OF CARE BEING PROVIDED.

BACKGROUND

NEARLY HALF OF ALL HOSPITALS PARTICIPATING IN MEDICARE, OR OVER 2,700 HOSPITALS, ARE LOCATED IN RURAL AREAS. IN 1984, THESE HOSPITALS ACCOUNTED FOR ABOUT ONE QUARTER OF ALL MEDICARE ADMISSIONS AND RECEIVED ABOUT 15 PERCENT OF MEDICARE PPS PAYMENTS, PRIMARILY BECAUSE THEY TREAT LESS SEVERE CASES WITH SHORTER LENGTHS OF STAY.

IN SPITE OF THE POSITIVE FINANCIAL POSITION OF THE LARGE MAJORITY OF RURAL HOSPITALS, WE ARE AWARE OF CONCERNS ABOUT RURAL HEALTH RESOURCES. THESE CONCERNS STEM, IN

PART, FROM THE MORE LIMITED ABILITY OF RURAL HOSPITALS TO IMPLEMENT THE NECESSARY EFFICIENCIES PROMPTED BY THE PPS BECAUSE OF THEIR HISTORICALLY SMALLER SIZE AND SCOPE OF SERVICES. IN ADDITION, BECAUSE OF CHANGING POPULATIONS IN THEIR SERVICE AREAS, RURAL HOSPITALS MAY HAVE GREATER DIFFICULTY IN MAINTAINING OCCUPANCY LEVELS.

WE WANT TO BE RESPONSIVE TO PPS PAYMENT PROBLEMS THAT WE CAN DEFINE AND WHERE WE CAN PINPOINT THE CAUSE. NEVERTHELESS, WE BELIEVE THAT REALISTICALLY IT IS NOT POSSIBLE TO ACHIEVE A PERFECT PRICE REGULATORY SYSTEM, SUCH AS PPS, BASED AS IT IS ON AVERAGES. REFINING PPS PAYMENTS OFTEN RESULTS SIMPLY IN A REALLOCATION OF MONEY, WITH THE CONSEQUENT "WINNERS AND LOSERS."

BEFORE ANY FURTHER COMPLICATING CHANGES ARE CONSIDERED TO ASSIST RURAL HOSPITAL, IT IS ESSENTIAL THAT WE IDENTIFY THE EXACT NATURE AND MAGNITUDE OF THE PROBLEMS THEY ARE EXPERIENCING. A NUMBER OF STUDIES, WHICH I MENTIONED EARLIER, HAVE ALREADY BEEN CONDUCTED WHICH EXAMINED THE FINANCIAL STATUS OF HOSPITALS, BOTH URBAN AND RURAL. BECAUSE OF THE LIMITED AVAILIABITY OF PPS COST DATA AT THAT TIME, THESE STUDIES DID NOT PRESENT A CONSISTENT PICTURE. WE NOW HAVE A NUMBER OF STUDIES IN THE PLANNING

STAGES AND UNDERWAY TO EXAMINE MORE PRECISELY THE IMPORTANT ISSUES CONCERNING RURAL HOSPITALS. THESE STUDIES ARE COMPLEX AND OFTEN HAVE HAD TO BE MODIFIED IN MIDSTREAM BECAUSE OF SUCCEEDING CHANGES TO THE PROSPECTIVE PAYMENT SYSTEM. IN ADDITION, COMPLETION OF THE STUDIES HAS OFTEN BEEN DELAYED BY THE UNAVAILABILITY OF RELIABLE COST DATA. THOSE DATA HAVE RECENTLY BECOME AVAILABLE THROUGH THE 1984 HOSPITAL COST REPORTS. AS THEY PROGRESS, THESE STUDIES, WHICH I WILL DISCUSS LATER, WILL CERTAINLY PUT US IN A BETTER POSITION TO IDENTIFY WHETHER REFINEMENTS ARE APPROPRIATE FOR RURAL HOSPITALS.

RURAL HOSPITAL PROVISIONS

TODAY, I WOULD LIKE TO PROVIDE YOU WITH A SUMMARY OF THE STATUS OF RURAL HOSPITALS UNDER PPS AND DESCRIBE OUR ACTIVITIES CONCERNING RURAL ISSUES.

PAYMENT RATES

DURING THE DEVELOPMENT OF THE PROSPECTIVE PAYMENT LEGISLATION IN 1983, CONGRESS WAS CONCERNED ABOUT ACCOUNTING FOR THE VARIATIONS IN CIRCUMSTANCES AND COSTS EXPERIENCED BY URBAN AND RURAL HOSPITALS. CONSEQUENTLY, THE FINAL LEGISLATION PROVIDED FOR BLENDED RATES WITH STANDARDIZED AMOUNTS TO BE COMPUTED FOR BOTH URBAN AND RURAL HOSPITALS WITHIN 9 CENSUS DIVISIONS, AS WELL AS

NATIONALLY. URBAN AREAS ARE DEFINED AS METROPOLITAN STATISTICAL AREAS (MSAS) AND EQUIVALENT LOCALES; ALL OTHER AREAS ARE RURAL. THE DETERMINATION OF WHETHER AN AREA IS URBAN OR RURAL IS MADE BY THE OFFICE OF MANAGEMENT AND BUDGET AND IS PERIODICALLY CHANGED BASED ON SHIFTING DEMOGRAPHIC, ECONOMIC AND SOCIAL FACTORS.

OTHER PROVISIONS WERE INCLUDED IN THE PPS LEGISLATION TO ASSURE THE EQUITABLE TREATMENT AND FINANCIAL VIABILITY OF RURAL HOSPITALS, INCLUDING ALLOWING THEM TO QUALIFY AS CERTAIN TYPES OF HOSPITALS WITH APPROPRIATE ADJUSTMENTS IN MEDICARE PAYMENTS. MOST RURAL HOSPITALS TO WHICH PPS APPLIES ARE SHORT-TERM, ACUTE-CARE HOSPITALS THAT ARE DISTINCTIVE MORE BECAUSE OF THEIR RURAL SETTING THAN BECAUSE OF ANY PARTICULAR TYPE OF SERVICE OR PATIENT MIX. HOWEVER, BECAUSE SOME RURAL HOSPITALS MAY FACE UNIQUE CIRCUMSTANCES, THE PPS LEGISLATION MAKES SPECIAL PROVISION FOR CERTAIN HOSPITALS SUCH AS SOLE COMMUNITY PROVIDERS AND REGIONAL REFERRAL CENTERS.

SOLE COMMUNITY PROVIDERS

A HOSPITAL CAN BE CLASSIFIED AS A SOLE COMMUNITY PROVIDER IF:

o IT IS LOCATED IN A RURAL AREA ISOLATED BY MORE THAN 50 MILES FROM A HOSPITAL PROVIDING SIMILAR SERVICES; OR o It meets certain criteria regarding admissions patterns, bed capacity and local weather and road conditions.

The majority of the current 359 sole community hospitals qualify due to isolated locations making them the sole source of inpatient services reasonably available in a given geographic area.

Sole community providers are paid a rate based on the 75 percent hospital-specific and 25 percent Federal rate blend applicable for the first year of the transition period for all PPS hospitals. Unlike other hospitals under PPS which will eventually be paid on a fully national Federal rate, sole community providers will remain at the 75/25 ratio.

Further, sole community hospitals may receive additional payments if they experience a decrease of more than 5 percent in total discharges due to circumstances beyond their control. To date, 7 sole community hospitals have applied for additional payments, which will be made to those who qualify based on documentation demonstrating the reasonable cost of necessary core staff, the hospital's fixed cost, and the length of time the hospital has

EXPERIENCED DECREASED UTILIZATION. ALTHOUGH THERE IS NO STATUTORY AUTHORITY TO CONTINUE THIS VOLUME ADJUSTMENT BEYOND THE TRANSITION PERIOD, WE ARE STUDYING EQUITABLE METHODS OF PAYING SOLE COMMUNITY HOSPITALS THAT TAKE INTO ACCOUNT THEIR VULNERABILITY TO VARIATIONS IN OCCUPANCY.

REGIONAL REFERRAL CENTERS

IN ADDITION TO QUALIFYING FOR SOLE COMMUNITY PROVIDER STATUS, HOSPITALS IN RURAL AREAS MAY QUALIFY AS REFERRAL CENTERS. BY ESTABLISHING CRITERIA FOR REFERRAL CENTERS, WE CAN ADDRESS THE PROBLEMS OF RURAL HOSPITALS WHICH OFFER A COMPREHENSIVE RANGE OF COMPLEX SERVICES, SERVE AS REGIONAL RESOURCES AND THEREFORE HAVE COSTS WHICH ARE NOT TYPICAL OF RURAL HOSPITALS. TO QUALIFY, HOSPITALS MUST:

o HAVE AT LEAST 500 BEDS, OR

o HAVE 50 PERCENT OF THEIR MEDICARE PATIENTS REFERRED FROM OTHER HOSPITALS OR NONSTAFF PHYSICIANS, AND DEMONSTRATE CERTAIN PATTERNS OF ADMITTING AND PROVIDING SERVICES TO MEDICARE PATIENTS WHO LIVE AT LEAST 25 MILES FROM THE HOSPITAL, OR

- DEMONSTRATE CHARACTERISTICS OF URBAN HOSPITALS. THIS ALTERNATIVE TO QUALIFYING AS A REGIONAL REFERRAL CENTER WAS ADDED BY THE DEFICIT REDUCTION ACT OF 1984 (DEFRA). TO QUALIFY, HOSPITALS MUST HAVE A CASE-MIX INDEX EQUAL TO THE NATIONAL OR MEDIAN URBAN REGIONAL VALUE; HAVE 6,000 DISCHARGES ANNUALLY; AND MEET ONE OF THREE OTHER CRITERIA DEALING WITH THE QUALIFICATIONS OF THE MEDICAL STAFF, THE SOURCE OF INPATIENTS AND THE VOLUME OF REFERRALS.

  IN ADDITION, AS A RESULT OF THE RECENTLY ENACTED CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA), RURAL OSTEOPATHIC HOSPITALS MAY QUALIFY AS REFERRAL CENTERS WITH A LOWER NUMBER OF DISCHARGES; THAT IS, 3,000 RATHER THAN THE 6,000 FOR OTHER REFERRAL CENTERS.

HOSPITALS MEETING ONE OR MORE OR THESE CRITERIA WILL BE PAID USING THE URBAN STANDARDIZED AMOUNT OF THE PAYMENT RATE, ADJUSTED BY THE HOSPITALS' WAGE INDEX. TO DATE, 166 HOSPITALS HAVE QUALIFIED FOR PAYMENT AS RURAL REFERRAL CENTERS, WITH EACH HOSPITAL RECEIVING AN ESTIMATED ADDITIONAL $600,000 ANNUALLY BECAUSE OF THIS DESIGNATION.

SWING BED HOSPITALS

IN 1980, PRIOR TO THE PASSAGE OF THE PPS LEGISLATION, PROVISIONS WERE ENACTED TO PERMIT RURAL HOSPITALS WITH FEWER THAN 50 BEDS TO "SWING" BEDS FROM AN ACUTE LEVEL OF CARE TO A SKILLED LEVEL AS PATIENT NEEDS FLUCTUATE. WHILE REIMBURSEMENT FOR SKILLED CARE IS AT A LOWER RATE THAN FOR ACUTE CARE, THE PROGRAM ENABLES SMALL HOSPITALS TO MAINTAIN HIGHER OCCUPANCY LEVELS, GENERATING REVENUES FROM BEDS THAT WOULD OTHER WISE REMAIN EMPTY, AND PROVIDING MEDICARE BENEFICIARIES IN RURAL AREAS, WHERE THERE IS A SHORTAGE OF SKILLED NURSING FACILITIES, BROADER ACCESS TO CARE. TO DATE, 771 HOSPITALS ARE PARTICIPATING IN THE SWING BED PROGRAM, INCLUDING 56 IN MINNESOTA, 75 IN KANSAS, 31 IN MONTANA, 18 IN OKLAHOMA, 14 IN LOUISIANA, 11 IN WYOMING AND ONE IN PENNSYLVANIA. AT LATEST COUNT 17 STATES ALLOW REIMBURSEMENT UNDER THE MEDICAID PROGRAM FOR SWING BED CARE, INCLUDING 15 THAT COVER SERVICES AT THE INTERMEDIATE LEVEL OF CARE.

OTHER PROVISIONS CONCERNING URBAN/RURAL CLASSIFICATIONS

LET ME MENTION SEVERAL OTHER PROVISIONS WHICH HAVE AFFECTED RURAL HOSPITALS. IN JUNE 1983, 49 COUNTIES WERE REDESIGNATED BY THE OFFICE OF MANAGEMENT AND BUDGET FROM

AN URBAN TO RURAL AREA. HOSPITALS LOCATED IN AREAS RECLASSIFIED AS RURAL WERE EXPECTED TO EXPERIENCE LOWER PAYMENTS AS A RESULT OF THIS SHIFT IN STATUS. HOWEVER, DEFRA AMENDMENTS PROVIDED FOR A TWO-YEAR TRANSITION PERIOD FOR REDESIGNATED HOSPITALS TO BECOME ACCUSTOMED TO THEIR NEW CLASSIFICATION. PAYMENT IS BEING ADJUSTED FOR 51 HOSPITALS FOR THE DIFFERENCE BETWEEN THE URBAN AND RURAL RATES DURING THIS TIME TO EASE THE IMPACT OF LOWER PAYMENT RATES.

OTHER RURAL HOSPITALS THAT BORDER ON METROPOLITAN AREAS HAVE VOICED THE BELIEF THAT THE COSTS THEY TYPICALLY INCUR ARE MORE SIMILAR TO URBAN HOSPITALS THAN OTHER RURAL HOSPITALS. INITIAL STUDIES HAVE SHOWN, IN FACT, THAT THESE HOSPITALS HAVE DONE LESS WELL IN THE FIRST YEAR OF PPS THAN HAVE RURAL HOSPITALS ONE OR TWO COUNTIES REMOVED. WE RECOGNIZE THAT THE CURRENT MSA/NON-MSA DEFINITIONS MAY NOT PRECISELY ACCOUNT FOR WIDELY VARYING HOSPITAL LABOR MARKET CONDITIONS, ESPECIALLY AMONG RURAL COUNTIES. WE AGREE WITH THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION (PROPAC) THAT LABOR MARKET AREA DEFINITIONS NEED TO BE IMPROVED AND WE ARE LOOKING AT ALTERNATIVE MEANS OF CLASSIFYING COUNTIES TO MORE APPROPRIATELY REFLECT HOSPITAL LABOR MARKETS.

I WOULD ALSO LIKE TO NOTE THAT WE HAVE IMPLEMENTED A NEW WAGE INDEX FOR ADJUSTING THE LABOR COMPONENT OF THE PAYMENT RATE. BY DISTINGUISHING BETWEEN FULL AND PART-TIME EMPLOYEES, THE NEW WAGE INDEX MORE ACCURATELY REFLECTS THE ACTUAL WAGE LEVELS OF THE URBAN OR RURAL AREAS IN WHICH HOSPITALS ARE LOCATED.

DISPROPORTIONATE SHARE HOSPITALS

ANOTHER OF THE CURRENT ISSUES CONCERNING THE PPS PROGRAM IS THE EXTENT TO WHICH PAYMENT ADJUSTMENTS SHOULD ADDRESS HOSPITALS SERVING A DISPROPORTIONATE SHARE OF LOW INCOME AND MEDICARE PATIENTS. PROVISIONS RECENTLY ENACTED IN THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 ESTABLISH SEPARATE DEFINITIONS OF DISPROPORTIONATE SHARE FOR BOTH URBAN AND RURAL HOSPITALS. UNDER THESE DEFINITIONS, RURAL HOSPITALS WITH 45 PERCENT OF PATIENT DAYS ATTRIBUTABLE TO LOW INCOME PATIENTS WOULD HAVE THE FEDERAL STANDARDIZED AMOUNT OF THE PAYMENT RATE INCREASED BY FOUR PERCENT. LOW INCOME PATIENT DAYS ARE DEFINED BY A FORMULA SPECIFIED IN THE LAW WHICH TAKES INTO ACCOUNT THE NUMBER OF INPATIENT DAYS UTILIZED BY FEDERAL SUPPLEMENTAL SECURITY INCOME (SSI) AND MEDICAID RECIPIENTS. WE HAVE RECENTLY ISSUED INSTRUCTIONS TO OUR FISCAL INTERMEDIARIES

TO IDENTIFY HOSPITALS MEETING THE DEFINITION OF DISPROPORTIONATE SHARE. WE HAVE PROVIDED THE INTERMEDIARIES WITH SSI DATA TO BE USED ALONG WITH MEDICAID DATA REPORTED BY HOSPITALS IN DETERMINING WHETHER ADDITIONAL PAYMENTS WILL BE MADE. INTERMEDIARIES WILL BEGIN PAYING HOSPITALS THE DISPROPORTIONATE SHARE ADJUSTMENT FOR DISCHARGES ON OR AFTER MAY 1 AS SOON AS PRACTICABLE. IF NECESSARY, RETROACTIVE ADJUSTMENTS WILL BE MADE.

WE HAVE ALSO BEEN TRYING, THROUGH A NUMBER OF METHODS, TO ACCURATELY DEFINE DISPROPORTIONATE SHARE HOSPITALS. TO DATE, THE DATA THAT HAVE BEEN AVAILABLE HAVE NOT PROVIDED VALID AND RELIABLE RESULTS. HOWEVER, WE ARE ANALYZING THE RECENTLY RECEIVED COST REPORT DATA FROM FY 1984 TO DETERMINE THE RELATIONSHIP BETWEEN MEDICARE AND MEDICAID UTILIZATION AND MEDICARE OPERATING COSTS PER DISCHARGE. WE ARE ALSO CONTINUING WITH THE COMMITTEE'S RECOMMENDED STUDY TO ESTIMATE THE PROPORTION OF EACH HOSPITAL'S MEDICARE PATIENTS HAVING LOW INCOMES ON THE BASIS OF THE HOSPITAL'S PROPORTION OF MEDICARE PATIENTS FROM LOW-INCOME ZIP CODE AREAS. WE EXPECT TO HAVE RESULTS FROM BOTH THESE EFFORTS LATER THIS YEAR.

RURAL HEALTH CLINICS

FINALLY, LET ME BRIEFLY MENTION ONE OTHER HEALTH CARE PROVIDER WHICH, ALTHOUGH NOT A HOSPITAL, BROADENS ACCESS TO PRIMARY MEDICAL SERVICES IN RURAL COMMUNITIES. RURAL HEALTH CLINICS MAY BE AFFILIATED WITH ANOTHER MEDICARE PROVIDER OF SERVICES OR BE AN INDEPENDENT FACILITY. THE CLINICS RECEIVE COST-BASED REIMBURSEMENT FOR PHYSICIAN SERVICES AND FOR MEDICAL SERVICES PROVIDED BY NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS. IN 1985, ALMOST $6 MILLION WAS REIMBURSED TO 428 RURAL HEALTH CLINICS.

RESEARCH ACTIVITIES

IN ADDITION TO THE STUDIES I HAVE JUST MENTIONED REGARDING THE WAGE INDEX AND DISPROPORTIONATE SHARE, WE ARE ALSO CONDUCTING SEVERAL OTHER STUDIES DEALING WITH RURAL ISSUES. LET ME BRIEFLY MENTION THE MAJOR ACTIVITIES.

SOLE COMMUNITY PROVIDERS

THE PROSPECTIVE PAYMENT LEGISLATION MANDATED A NUMBER OF STUDIES, INCLUDING SEVERAL SPECIFICALLY RELATED TO RURAL ISSUES. WE HAVE RECENTLY COMPLETED THE REQUIRED STUDY ON EQUITABLE METHODS OF PAYING SOLE COMMUNITY PROVIDERS. THE STUDY LOOKED AT SUCH ISSUES AS DIFFERENCES IN CASE-MIX, CHANGING THE CURRENT PAYMENT BLEND, AND MODIFYING THE PROVISION FOR PAYMENTS FOR DECREASES IN ADMISSIONS. THE REPORT IS CURRENTLY UNDER REVIEW WITHIN THE DEPARTMENT.

URBAN/RURAL DISTINCTIONS

WE HAVE ALMOST COMPLETED THE STUDY OF ISSUES CONCERNING URBAN/RURAL DISTINCTIONS. THE REPORT WILL ENCOMPASS SEVERAL SEPARATELY MANDATED STUDIES BECAUSE OF THE INTERRELATIONSHIP OF THE URBAN/RURAL ISSUES. THE SINGLE REPORT WILL ADDRESS PHASING OUT SEPARATE URBAN AND RURAL RATES, THE INCLUSION OF A REGIONAL COMPONENT IN THE PPS RATES, VARIATION BY DRG IN THE LABOR AND NONLABOR PORTIONS OF THE RATE, AND OTHER ISSUES AFFECTING RURAL HOSPITALS SUCH AS PAYMENT FOR OUTLIERS. WE HAD ORIGINALLY INTENDED TO INCLUDE THE RESULTS OF OUR STUDY ON THE APPROPRIATENESS OF PAYMENTS TO RURAL REFERRAL CENTERS IN THIS REPORT, BUT WILL BE UNABLE TO DO SO BECAUSE COST REPORT DATA, NECESSARY TO COMPLETE THE STUDY, HAS JUST RECENTLY BECOME AVAILABLE.

SWING BED PROGRAM

WE ARE EVALUATING THE IMPACT OF THE SWING BED PROGRAM ON THE ACCESS, QUALITY AND COST OF LONG-TERM CARE IN RURAL

AREAS AND EXPECT TO HAVE A REPORT AVAILABLE IN 1987. THE SWING BED PROGRAM WAS SLOW IN EVOLVING AND DID NOT GET OFF THE GROUND UNTIL 1984. WITH THE ENACTMENT OF PPS, THE NUMBER OF HOSPITAL ELECTING THE SWING BED OPTION ACCELERATED. THE NUMBER HAS INCREASED FROM 149 HOSPITALS IN DECEMBER 1983 TO 771 SWING BED HOSPITALS AT THE BEGINNING OF THIS YEAR. IT APPEARS THAT PPS HAS INCREASED THE ATTRACTIVENESS OF THE SWING BED OPTION. TO EXPLORE THE IMPACT OF PPS ON THE SWING BED PROGRAM, WE EXPANDED THE WORK BEING PERFORMED BY THE EVALUATION CONTRACTOR. WE WILL INCLUDE THE FINDINGS IN OUR PPS IMPACT REPORTS.

OTHER STUDIES

WE ARE ALSO MAKING PLANS TO STUDY THE IMPACT OF PPS POLICIES REGARDING OUTLIERS AND PATIENT TRANSFERS ON PAYMENTS TO RURAL HOSPITALS, ESPECIALLY THOSE WITH FEWER THAN 100 BEDS. THIS STUDY WAS MANDATED BY THE RECENTLY ENACTED COBRA LEGISLATION AND IS TO BE REPORTED TO CONGRESS BY JANUARY 1, 1987. IN ADDITION, AT THE DIRECTION OF THE SENATE APPROPRIATIONS COMMITTEE, WE ARE MAKING PLANS TO STUDY THE SHORT- AND LONG-RUN IMPACT OF PPS ON RURAL HOSPITALS.

CONCLUSION

IN CONCLUSION, LET ME SAY THAT WE RECOGNIZE THAT THE "REVOLUTION" THAT HAS TAKEN PLACE IN THE HEALTH CARE INDUSTRY IN BOTH THE FINANCING AND DELIVERY OF CARE OVER THE PAST SEVERAL YEARS HAS HAD A SIGNIFICANT IMPACT ON ALL PROVIDERS, INCLUDING RURAL HOSPITALS. WE ARE CLOSELY MONITORING THE DATA WE RECEIVE ON THE IMPACT OF THE PROSPECTIVE PAYMENT SYSTEM AND ARE DEVOTING CONSIDERABLE EFFORT TO EXAMINING ISSUES WHERE POSSIBLE PAYMENT REFINEMENTS WILL GO FURTHER TO PROTECT RURAL HOSPITALS.

HOWEVER, WE ARE PHILOSOPHICALLY SKEPTICAL ABOUT THE ABILITY TO CURE ALL ILLS HOSPITALS ARE ENCOUNTERING WITH A PRICE REGULATORY SYSTEM. INSTEAD, WE MUST LOOK TO NEW WAYS OF PROVIDING NECESSARY HEALTH CARE THAT RELY ON COMPETITIVE INCENTIVES TO ASSURE APPROPRIATE UTILIZATION AND QUALITY. WE HAVE MADE A DRAMATIC START IN THIS DIRECTION WITH THE MEDICARE HEALTH MAINTENANCE ORGANIZATION/COMPETITIVE MEDICAL PLAN PROGRAM, AND BELIEVE EXPANDING CAPITATION OPPORTUNITIES WILL OFFER ATTRACTIVE BENEFITS TO BOTH MEDICARE PATIENTS AND PROVIDERS.

IN THE MEANTIME, LET ME ASSURE YOU THAT WE HAVE NO INTENTION OF ENDANGERING THE ACCESSIBILITY OF NECESSARY CARE FOR OUR BENEFICIARIES IN RURAL SETTINGS. WE WILL ACTIVELY CONTINUE OUR EFFORTS TO INSURE THAT APPROPRIATE AND EQUITABLE PAYMENT IS MADE TO BOTH URBAN AND RURAL HOSPITALS.

Senator **Durenberger**. Alright, our next witnesses are a panel consisting of Joyce Jenson, vice president of National Research Corp. from Lincoln, NE; Ira Moscovice, doctor, associate director of Center for Health Science—Health Services Research from the University of Minnesota; Jeffrey Merrill is assistant vice president of Robert Wood Johnson Foundation and Dr. Anthony Kovner, professor and director of Program Health Policy Management from New York University, NY, and senior program consultant with the Robert Wood Johnson Foundation. Independent experts. Joyce we will begin with you. All of our witnesses have submitted statements, all of which will made part of the record and you may proceed to summarize those statements in 5 minutes or less. Thank you. Joyce.

STATEMENT OF JOYCE JENSEN, VICE PRESIDENT, NATIONAL RESEARCH CORP., LINCOLN, NE

Ms. **Jensen**. Senator, as we all know rural hospital have been hit hard by the DRG regulations which reimburse them for Medicare. As many of these facilities have more than their share of the elderly. And, with the accompanying inpatient lower occupancy levels, real hospital administrators are scrambling to keep their hospital viable.

But, they are not just sitting back, they are not just waiting to be rescued. They are studing their markets. They are talking to people in their communities about their medical needs and how that hospital can help to provide them.

They are actively recruiting physicians, sometime through joint ventures. They are entering into shared arrangements and hospital alliances to gain knowledge from other members. And, they are diversifying into other areas, making the most sense for their situations. Oftentimes for long-term care or for outpatient services.

The purpose of my testimony is to provide a broad basic perspective on rural hospital administrators 'view on the current situations and anticipated strategies continued viability.

This is perspective is based upon ongoing national research studies that we do of hospital administrators across the country, both of rural and urban hospitals, and also on national surveys we do of consumers across the Nation. And, yet, another perspective comes from working on a one-on-one basis with rural hospitals to assess their markets.

Through these studies rural hospitals are asking pointed questions to their comunities. Are people going out of the area for services and if they are, where and for which services? And, most importantly, what can be done to keep those health dollars in the local community?

What are they finding? On a national basis they are finding that 4 out of 10 people think they are not sophisticated in specialized medical facilities in their area. Three out of ten people across the Nation say they are actually going out of the area to receive these services. Half of the time they are going out to see specialists, physician specialists, and tertiary care. A fourth of these are going out of the area just for inpatient hospitalization, not necessarily for specialized hospitalization, and for testing.

The remaining quarter are going out of their areas for all types of medical care, icluding regular physician relationships. And, when residents are leaving the area for physician care the rural hospital business looks really bleak.

In order to prevent losing these patients to their metropolitan neighbors, rural hospitals are trying to convince local residents that they do provide care there. No. 2, they are trying to focus their energy on recruiting quality physicians.

Oftentimes residents are unaware of what the hospital does provide. Rural hospitals are now informing them. They are also using sales people out to businesses and to their physicians, which brings up the physician component.

The physician relationship becomes extremely important in rural hospitals, not only in trying to increase referrals by onstaff physicians, but in developing new staff relationships by relocating physicians to their communities. Even with the increasing oversupply of physicians, many rural areas have trouble recruiting. Larger metropolitan areas obviously have the advantages of more cultural and social offerings.

Physician arrangements that have been working though are ones where rural hospital associate with group practices or clinics, whereby physicians and specialists, and surgeons are sent to rural areas on designated days of the week to provide medical care. That's referring patients, who can be referred to the local hospital, the small rural hospital, there the others being admitted to metropolitan facilities.

The rural hospitals are facing a new challenge as the urban facilities start putting satellite centers there to start draw in those patients.

As we are all aware the occupancy levels have declined. Sixty-percent of rural facilities say they have not made a profit in the last year. Seven out of ten rural facilities have experienced occupancy declines.

Most hospitals are going to diversifiction in order to make up some of the difference, but they cannot always diversify the way that a large hospital can, mainly because of their capital and financing problems.

Nursing homes, swing bed programs, outpatient services, contract management for technical expertise, shared services, and so forth are ways they are trying to handle the problem. With all the problems that rural hospitals are facing, they evidently are looking at them as opportunities, because they are not giving up.

When we asked rural hospitals across the nation, what they would have to do in order to stay viable, only 5 percent they would have to merge with larger institutions.

Rural hospitals do serve a real need and see this also from coming from southwestern Nebraska where the the closest hospital was 40 miles away and that was a rural facility. The closest urban hospital was 200 to 300 miles away.

We need to continue to support them in their situations need to be understood, so, that the reimbursement legislation will help insure their viability. Thank you.

[The personal statement of Ms. Jensen is to follow:]

Finance Committee Subcommittee on Health to Examine Rural Hospitals Under the Medicare Program
Hearing - May 9, 1986
Statement
By: Joyce Brubaker Jensen
National Research Corporation
Lincoln, Nebraska

The purpose of my testimony is to provide a broad, basic perspective on rural hospital administrators' views on the current situations and anticipated strategies for continued viability.

This perspective is based upon ongoing national marketing research studies of hospital administrators from both the rural and metropolitan sectors. The studies, conducted by National Research Corporation, Lincoln, Nebraska, questioned administrators on various topics to determine their views and response to the changing healthcare provider business. NRC also conducts ongoing studies of consumers on a national basis to determine their needs and viewpoints regarding changes made by healthcare providers.

And yet another perspective comes from working on a one-on-one basis with rural hospitals to assess their markets. Through market research studies, rural hospitals are asking pointed questions to their communities -- are they going out of the area for services, and if so, where? And for which services? And, most importantly, what can be done to keep those healthcare dollars in the local community?

What are they finding?

On a national basis, four out of 10 (42%) consumers located in non-metropolitan areas of the nation say they do not believe specialized and sophisticated medical services are available in their areas. Three out of 10 people interviewed by NRC in September, 1985, said they have gone to larger population centers in order to receive specialized medical care.

They are traveling to nearby communities to access physician specialists, hospitals and more sophisticated testing facilities than are available locally. Of those leaving their areas to receive medical attention, almost half are doing so to be treated by a physician specialist. Most often these are cardiac or cancer specialists, but general women's OB/GYN services are also being sought.

Another one-fourth have used hospitals or other surgical facilities and a smaller segment have traveled for testing facilities. And 22% of those who travel outside their areas for health care do so for all types of medical care, including for general practitioners or family physicians.

And when residents are leaving the area for physician care, the hospital business looks bleak.

In order to prevent losing these patients to their metropolitan neighbors, rural hospitals are doing a couple of things: 1) trying to convince local residents that their hospitals do indeed provide not only high quality general services, but also a number of specialized services and, 2) focusing their energy in recruiting quality physicians.

Informing Community

Oftentimes local residents are unaware of medical services provided in their communities. To remedy this, many rural hospitals are relaying the message to their communities through the advertising vehicle. Eighty percent of rural hospitals are advertising their institutions and/or their services and classes to the general public. Though their advertising budgets as a rule are much smaller than metropolitan hospitals, the overall usage of advertising by rural hospitals is similar to metropolitan facilities.

And to the other sectors, rural hospitals are using sales people in their marketing efforts. Almost one in 10 (9%) rural hospitals are currently utilizing a sales person to market to local businesses and physicians.

This brings us to the physician component.

The physician relationship becomes extremely important in these rural hospitals, not only in trying to increase referrals by on-staff physicians, but also in developing new staff relationships by relocating physicians to their communities. Even with the increasing oversupply of physicians, many rural areas have trouble recruiting. Larger metropolitan facilities are doing a great deal to cement physician relationships, such as advertising the physician services, directors and assisting in setting up their practices. Rural hospitals are now becoming more involved in these types of arrangements also to insure physician recruitment, but often have a disadvantage, as it is hard for the rural hospital to match the cultural and sound offerings of metropolitan areas.

Three out of 10 (29%) rural hospitals are forming joint ventures with physicians and another two out of 10 (20%) are planning to implement this procedure to procure qualified physicians to their areas.

Other physician arrangements include arrangements with group practices or clinics whereby physicians, specialists and surgeons are sent to rural areas on designated days of the week to provide medical care on a regular basis. This prevents residents from seeking care in metropolitan areas. Thus, those cases which can be handled at the local hospital are admitted there and the more specialized cases are admitted to metropolitan area hospitals.

But, rural hospitals are facing a new challenge from urban hospitals who are developing networks of satellite facilities, such as physician clinics or ambulatory care centers, in the rural communities. Thus, some patients are being drawn to the larger metropolitan areas who could legitimately be cared for in the local community.

Occupancy Declines

As we are all aware, occupancy levels in many rural hospitals have hit bottom. In NRC's 1985 National Study of Hospital Administrators, seven out of 10 rural facilities reported occupancies of less than 60% compared to three out of 10 metropolitan hospitals noting occupancies under 60%. And rural hospitals are not as able to withstand lower occupancies as well as their metropolitan neighbors. Along with these decreased occupancies, and thus decreased revenue, 60% of rural hospitals report not having made a profit during their last fiscal year. One-fourth of these rural hospitals indicate it is costing them more to provide the services to Medicare patients than the amount being reimbursed by the government under the DRG system. This is especially true in those hospitals with lower occupancies.

Compensation For Lower Occupancies

Twenty percent of rural hospitals think diversification is the answer to remaining viable in the upcoming five years. Though rural hospitals have diversified to some extent, most of them have limited resources with which to do so, as is evidenced by their citing finances and capital as the most pressing problems facing them today. And rural hospitals can't always diversify the way a large hospital can. For example, most rural hospitals couldn't generate enough enrollees to support their own HMO or PPO.

Due to limited diversification opportunities, rural hospitals are looking at reverting back to being primary care providers as opposed to offering a multitude of services. They are looking at diversifying in a direction in which they have some already-established resources -- to providing ongoing care for those residents in their communities.

Nursing Homes

One way rural hospitals are compensating for their low occupancies is by becoming licensed to convert unused patient wings into nursing home units in order to offset fixed costs. The fact that many elderly people live in rural areas and wish to stay close to their friends and relatives gives the nursing home transition widespread appeal. One-third (32%) of rural facilities currently are offering nursing home facilities through or in conjunction with their hospitals, meaning some nursing home units offered by rural hospitals are as a satellite facility.

Outpatient Services

Another way of compensating for lower inpatient admissions is through increased usage of outpatient facilities. An additional 15% of rural hospitals had experienced increased usage of their outpatient services in 1985 as compared to 1984, with plans made to increase usage in 1986.

Contract Management

Behind the scenes, contract management and shared services are playing a big role in rural institutions' survival. Half of all rural hospitals have at least one department under contract management -- 38% of those who are contracting have contracted one department, 31% two departments, 15% three departments, 13% four departments, and the remaining 3% have five or more services being contracted outside.

Though many hospitals turn to contract management as a way of saving money, the majority cite recruitment as the primary reason they are using contract management. Of those rural hospitals using outside contract management firms, four out of 10 say the reason is for the recruiting of skilled technicians compared to two of 10 citing cost savings. Rural hospitals are most likely to contract services such as respiratory therapy, pharmacy or physical therapy.

Shared Services

Rural hospitals are realizing that they need to join other organizations to attain "strength in numbers" -- and they can still maintain autonomy and control through shared services and multiple hospital alliances and purchasing organizations.

Conclusion

With all the problems rural hospitals are facing they evidentally are looking upon them as opportunities, as few are ready to give up. When rural hospital administrators were asked what they thought they would have to do in order to stay solvent and viable in the upcoming years, only 5% suggested consolidating or merging with other institutions. They do, however, feel they need to contain or reduce costs, get involved in marketing and strategic planning, and diversify in a direction in which they have already established resources.

Senator **Dole**. Next we will hear from Dr. Ira Moscovice.

STATEMENT OF IRA MOSCOVICE, PH.D., ASSOCIATE DIRECTOR, CENTER FOR HEALTH SERVICES RESEARCH, UNIVERSITY OF MINNESOTA, MINNEAPOLIS, MN

Dr. **Moscovice**. Thank you, Senator Dole and Senator Baucus. The recent replacement of the Medicare cost based reimbursement system with PPS signified a landmark effort to encourage the efficient provision of inpatient hospital services.

PPS was developed with the intent to change the behavior of health institutions and professionals responsible for providing inpatient services. Potential hospital responses to this new mode of reimbursement include: Decreasing length of stay, decreasing and/or using different inputs in the production process, moving services outside the hospital, specializing in selected services, diversifying the hospital product line and increasing volume in profitable services.

Some hospitals have been able to significantly improve their operating margin under PPS by using one or more of these approaches. These hospitals are more likely to be larger hospitals located in urban settings.

On average, rural hospitals have simply not fared as well as other hospitals under PPS. Approximately one-third of rural hospitals in the midwest lost money in 1984, with close to one-half in 1985. Reasons for the poorer economic conditions for rural hospitals under the PPS environment include: Rural hospitals have experienced greater proportionate reductions in the their volume of hospital admissions and length of stay as compared to urban hospitals. This decreased patient day base has resulted in increased average cost per case in many rural facilities and has made it more difficult for these facilities to cover their fixed expenses.

Second, rural hospitals are more dependent on Medicare revenues for their financial stability than urban hospitals. Substantial reductions in Medicare revenues cannot be offset by the limited private pay patient base at most rural hospitals.

Rural hospitals are simply trapped by the economies of scale argument. As one colleague has suggested, rural hospitals are not able to lose some on each case, but make it up on volume.

Third, many rural hospitals had very limited operating margins prior to PPS. They are unable to balance reduced Medicare revenues with their existing hospital reserves and operating margin.

Fourth, the depressed rural economy has substantially increased the burden hospitals to provide uncompensated care. This extra burden reduces the ability of rural hospitals to operate in the PPS environment.

Fifth, the PPS system created differences between urban and rural payment rates. In some sense, hospitals were penalized for their lower average costs in the past. Although different payment rates may be appropriate for some of the patients treated in rural hospitals, they are certainly not appropriate for all patients treated in rural facilities.

Sixth, there have been technical and conceptual difficulties associated with the development of area wage indices in the designation of rural referral centers and sole community providers.

The Prospective Payment Assessment Commission has identified the area wage index issue as one immediate concern. Problems with the designation of rural referral centers in sole community providers should have been expected, given the dependence of PPS on the geographic location of hospitals.

Seventh, a few outlier cases or severely ill Medicare patients can literally bankrupt rural hospitals. Rural hospitals do not have a large enough volume of admissions to make up the losses associated with their outlier cases.

PPS will have a dramatic impact on the distribution of hospital revenues. At present, there are some big winners and big losers under PPS. Yet, it is not clear that a hospital's fate rests primarily with its ability to efficiently provide services.

In the short term, I have two recommendations concerning PPS. First, there should be a 1-year delay in the transition from payments based primarily on hospital's specific costs to payments based on national and regional cost averages.

PPS needs to become more sensitive to individual hospital differences. Efficient rural hospitals are not necessarily appropriately rewarded under the current PPS.

At the present time, transition to a PPS system based on national rates will make a difficult situation, potentially life threatening for many small rural hospitals. A 1-year delay is necessary to work out the technical and conceptual difficulties inherent in the current PPS system that threaten the viability of rural hospitals.

Second, the inequity and difference between rural and urban payment rates must be eliminated. PPS was designed to appropriately pay hospitals for the product that they produced. For similar patients, differences in payments should reflect differences in input prices of both labor and nonlabor factors and not reflect differences in geographic location.

A rural hospital should not be penalized because it is located near an urban area or because it is in a specific region of the country. Rural hospitals need to be able to compete on an equal basis.

The structure of the reimbursement system must reward the appropriate delivery of rural health services. The current PPS system must be adjusted so that accurate measurement of input prices and case mix are the primary basis of differential in payment rates. Geographic location should not be the driving force behind payment rate differentials.

There is a crisis in rural health care in the United States today. The financial viability of rural hospitals is at the center of the crisis. The economic problems of rural hospitals have been exacerbated by the implementation of PPS.

Yet, there are clearly other factors threatening the survival of rural hospitals, not the least of which is the demise of the rural economy. The future appears precarious for rural hospitals, continuation of the status quo will undoubtedly lead to more frequent closures of rural hospitals.

The rural hospital must assume a new role and mission if it is to remain a viable entity, yet, powerful external forces threaten its financial viability. Rural hospitals can be the conduit for change in rural communities, but they can only accomplish this goal if they are not overburdened with the cost containment efforts central to current Federal health policy.

Senator DURENBERGER. All right, thank you.

[The prepared statement of Dr. Moscovice follows:]

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Testimony on the Impact of the Medicare Prospective Payment System on Rural Hospitals

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Presented to the Subcommittee on Health of the
Committee on Finance of the United States Senate

Prepared by:

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May 9, 1986

INTRODUCTION

Rural America is in transition. This transition is being fueled by changes in basic social, economic, and demographic factors. A dramatic reversal in long term population trends occurred during the past decade. For the first time in this century, nonmetropolitan areas grew faster than metropolitan areas in the United States. However, in the past few years, these population increases have disappeared as the rural economy has weakened. Demographic shifts in rural areas will have important implications for the future status of rural health care systems.

Rural populations have traditionally lagged behind more densely populated regions in the acquisition of basic services, including health care. The relative deficiency of rural health resources is unambiguous. These deficiencies exist despite evidence of increased need for health services by rural populations, due to disproportionate subgroups of the elderly and the poor in rural areas.

The rural hospital is a vital component of the rural health care system and an important institution in rural communities from a functional, symbolic and economic perspective. The hospital, along with the church and the school, represent the elements through which rural communities define themselves. It is not by chance that rural communities continue to hold onto their hospitals.

In recent years, considerable concern has focused on the future of rural hospitals, many of which have experienced serious problems in maintaining financial viability. Rural hospitals have been labelled an endangered species because of their tenuous fiscal status. Many rural hospitals currently face declining occupancy rates, a reduced patient day base, decreased patient revenues, increased uncompensated care, and increased costs. The above symptoms of a fiscally troubled institution have resulted in increased average costs per patient day in rural hospitals, as the fixed costs of providing inpatient services must be allocated over a reduced patient day base.

The problems facing many rural hospitals today result from a number of interrelated factors that determine the environment within which the rural hospital operates and affect its performance. These factors include demographic changes (particularly the increased number of elderly living in rural communities), inadequate supply of personnel including physicians and nurses, difficulty with incorporating new technology, availability of capital, increased competition from providers' in saturated urban markets, and the restrictive reimbursment environment created by the dual pressure of public and private payors. Although the discussion today will focus on the impact of the Medicare Prospective Payment System (PPS) on rural hospitals, it is important to recognize that PPS is but one of many forces affecting the economic viability of rural hospitals.

RURAL HOSPITALS IN THE PPS ENVIRONMENT

The recent replacement of the Medicare cost based reimbursement system with the prospective payment system signified a landmark effort to encourage the efficient provision of inpatient hospital services. The prospective payment system was developed with the intent to change the behavior of health institutions and professionals responsible for providing inpatient services. Potential hospital responses to this new mode of reimbursement include decreasing length of stay, decreasing and/or using different inputs in the production process, moving services outside the hospital, specializing in selected services, diversifying the hospital product line, and increasing volume in profitable services. Some hospitals have been able to significantly improve their operating margin under the PPS system by using one or more of these approaches. These hospitals are more likely to be larger hospitals located in urban settings.

On average, rural hospitals have simply not fared as well as other hospitals under the PPS system. Approximately one-third of rural hospitals in the Midwest lost money in 1984 with this proportion expected to approach one-half in 1985. Reasons for the poorer economic condition of rural hospitals under the PPS environment include:

1. Rural hospitals have experienced greater proportionate reductions in their volume of hospital admissions and length of stay as compared to urban hospitals. This decreased patient day base has resulted in increased average costs per case in many rural facilities and has made it more difficult for these facilities to cover their fixed expenses.

2. Rural hospitals are more dependent on Medicare revenues for their financial stability than urban hospitals. Substantial reductions in Medicare revenues cannot be offset by the limited private pay patient base in most rural

hospitals. Rural hospitals are simply trapped by the economies of scale argument. As one colleague has suggested, rural hospitals aren't able to "lose some on each case, but make it up on volume."

3. Many rural hospitals had very limited operating margins prior to PPS. They are unable to balance reduced Medicare revenues with their existing hospital reserves and operating margin.

4. The depressed rural economy has substantially increased the burden on rural hospitals to provide uncompensated care. This extra burden reduces the ability of rural hospitals to operate in the PPS environment.

5. The PPS system created differences between urban and rural payment rates. In a sense, rural hospitals were penalized for their lower average costs in the past. Although different payment rates may be appropriate for some of the patients treated in rural hospitals, they certainly are not appropriate for all patients treated in rural facilities. It can cost the same amount of money to treat some patients in either a rural or urban facility.

6. There have been technical and conceptual difficulties associated with the development of area wage indices and the designation of rural referral centers and sole community providers. The development of appropriate area wage indices is central to the question of urban/rural payment differentials. The Prospective Payment Assessment Commission has identified this as an issue of immediate concern. Problems with the designation of rural referral centers and sole community providers should have been expected given the dependence of the PPS system on the geographic location of hospitals.

7. A few outlier cases/severely ill Medicare patients can literally bankrupt a rural hospital. Rural hospitals do not have a large enough volume of admissions to make up the losses associated with their outlier cases.

RECOMMENDATIONS FOR CHANGE

The PPS system will have a dramatic impact on the distribution of hospital revenues. At present, there are some big winners and big losers under PPS, yet it is not clear that a hospital's fate rests primarily with its ability to efficiently provide services.

In the short term, I have two recommendations for public policymakers concerning PPS. First, there should be a one year delay in the transition from payments based primarily on hospital specific costs to payments based on national and regional cost averages. PPS needs to become more sensitive to individual hospital differences. Efficient rural hospitals are not necessarily appropriately rewarded under the current PPS system. At the present time, transition to a PPS system based on national rates will make a difficult situation potentially life-threatening for many small rural hospitals. A one year delay is necessary to work out the technical and conceptual difficulties inherent in the current PPS system that threaten the viability of rural hospitals.

Second, the inequity in the difference between urban and rural payment rates must be eliminated. The PPS system was designed to appropriately pay hospitals for the "product" they produce. For similar patients, differences in payments should reflect differences in input prices (both labor and non-labor) and not reflect differences in geographic location. A rural hospital should not be penalized because it is located near an urban area or because it is in a specific region of the country. Rural hospitals need to be able to compete on an equal basis with urban hospitals. The structure of the reimbursement system must reward the appropriate delivery of rural health services. The current PPS system must be adjusted so that accurate measurement of input prices and casemix are the primary basis of differentials in payment rates. Geographic location should not be the driving force between payment rate differentials.

CONCLUSION

There is a crisis in rural health care in the United States today. The financial viability of rural hospitals is at the center of the crisis. The economic problems of rural hospitals have been exacerbated by the implementation of the PPS system. Yet there are clearly other factors threatening the survival of rural hospitals, not the least of which is the demise of the rural economy.

The future appears precarious for rural hospitals. Continuation of the status quo will undoubtedly lead to more frequent closures of rural hospitals in the future. The rural hospital must assume a new role and mission if it is to remain a viable entity, yet powerful external forces threaten its financial viability.

Rural hospitals can be the conduit for change in rural communities. They can only accomplish this goal if they are not overburdened with the cost containment efforts central to current federal health policy.

Senator Durenberger. Jeff Merrill.

STATEMENT OF JEFFREY C. MERRILL, ASSISTANT VICE PRESIDENT, ROBERT WOOD JOHNSON FOUNDATION, PRINCETON, NJ

Mr. Merrill. Thank you, Mr. Chairman. I would just like to briefly make five points if I can.

First of all, this is a real problem. I think you have heard that quite sincerely and importantly this morning. I do not say that as an advocate on—the foundation attempt to identify areas of concern in the health care system and then develop programs in some limited ways to address those.

As we examine problems created by the rapid changes in that system, the plight of rural hospitals became increasingly evident. I think, though the most important point here is it is not as though a million in the health care field acknowledge that this is a problem is they mitigate the importance of this problem. They consider these small isolated hospitals in as such are not as important to the system as the vast medical centers in large urban areas that treat larger groups of population.

Second, the problem of rural hospitals is not only rural hospitals, it is rural health care in general. The lack of a rural hospital has a lot to do with the attracting other physicians in other health care providers. Second, it is not only health care, as some people have said before, it is the economy of the area.

In attracting industry and in providing employment. I think we sometimes forget that health care is probably the single largest employer in the United States and that is certainly so in the rural areas as well.

The second point that I would like to make is that the problem of rural hospitals is not caused by any single item, rather it is a confluence of a lot of events that seem to be occuring at once, that are exacerbating difficulties.

Let me just briefly talk about four of those. One, we all know is declining utilization. Although, this is a problem in the country in general it is a particular problem for rural hospitals. In between 1980 and 1984 the decline in occupancy rate for hospitals under 60 beds dropped to 41 percent. These were hospitals that already have low occupancy rates and further declines were going to be considerably more important to their survival than they were for hospitals in general.

Second, I think we can ignore the farm crisis that is clearly affecting our country right now. In many of these hospitals, 50 percent are publically supported, often county institutions. And, the decline in revenue base of the rural area clearly has affected their ability to survive.

Also, while we have a problem in general with lack of health insurance for many of our people, I think this is particularly so in rural areas. In 1984 there were over a 11 million rural Americans without health care. So, even those, who did use these hospital often did not have any coverage to pay for these services.

Third, is the issue of competition, which while being extremely important in terms of the health care system has had some untoward effects on rural hospitals. It has exacerbated this situation in the sense that large urban hospitals are competing for this population. Often the inability of rural facilities to attract the sufficient manpower and to raise capital, to modernize their facilities has made them even more vulnerable to competition.

Fourth, and I think most important and I do not want to dwell on it, because it has been adequately addressed so far is the issue of prospective payment. Let me just underline two points as regard to that. One has to do with care for the poor. The teaching adjustment that is available to urban hospitals did not only reflect teaching costs but clearly reflected care to the poor. It was a way of adjusting for that. That benefit has not been made available to rural hospitals, which are seldom teaching hospitals. Therefore, something that has often saved hospitals that take care of a large percentage of the poor has not been available to them. The recent changes in the law with regard to disproportionate share have made some improvement in that, but I think to some extent it discriminated against rural hospitals by setting a very high threshhold, even qualified for and then a very low adjustment, once the—even if they do qualify.

Second, is the issue of the law of the law of large numbers, which has been mentioned. I think the whole success or failure of the prospective payment system is based upon the law of large numbers. Rural hospitals just do not have that and I think of that problem is clearly of concern.

Let me just quickly say that the issue is not one of closure or bailout, I think we sometimes make this a binary choice. I feel that there are a number of immediary steps that can be taken to address the issue, without closing a facility. Converting that facility to other purposes, regionalizing with other facilities in the area and downsizing existing fsacilties are all possible solutions.

In that respect, fourth, I think it should be pointed out that rural hospitals have not been passive. I think there are a lot of very exciting things that are going on around the country, that rural hospitals are attempting to address their situation. Let me just briefly mention a few.

In North Dakota, rural hospitals have formed a consortium to regionalize services more appropriately among the facilities. In North Carolina, rural hospitals are negotiating with large urban facilities to provide needed physicians, training and services and in turn they are referring more complex patients to those urban hospitals. In Kansas, the State Hospital Association is providing a team of consultants to help rural facilities address these issues.

Since my time is short, let me just include a fifth point, I think there is hope for the situation, however, I think this will require the necessary information and expertise be made available to hospitals, that some limited support must be necessary to them. At least the hospitals receive equitable treatment through the reimbursement system. Lastly, that we recognize that this is simply not a problem with health care in some small communities, but it a problem that affects almost half out citizens and is related to the overall economic well being of our nation. Thank you.

Senator **DURENBERGER**. Thank you.

[The prepared statement of Mr. Merrill follows:]

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United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510

May 15, 1986

Anthony R. Kovner, Ph.D., Director
Rural Hospital Program of Extended
Care Services
New York University
113 University Place, Ninth Floor
New York, New York 10003

Dear Dr. Kovner:

To follow-up on your testimony at the May 9, 1986 Subcommittee on Health hearing on the status of rural hospitals under the Medicare program, Senator Packwood would like you to answer the attached question.

Your response should be typed on letter-size paper and double spaced. To meet our printing schedule, please provide your answer no later than June 6, 1986. Send your response to:

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, D.C. 20510

If you have any questions, Ms. Salmon may be reached at 202/224-4515.

Sincerely,

EDMUND J. MIHALSKI, C.P.A.
Deputy Chief of Staff
for Health Policy

Follow-Up Question from Senator Packwood for Anthony Kovner, Ph.D.

1. Have you found that there are any differences in receptivity (from patients, hospital administrators, state officials, long-term care interests, etc) to the swing bed approach in the 5 States included in your swing bed demonstration?

   Are there areas of the country where the swing bed approach is more or less appropriate?

(C0549)

New York University
A private university in the public service

Rural Hospital Program of Extended-Care Services

113 University Place, Ninth Floor
New York, N.Y. 10003
Telephone: (212) 598-7057

May 22, 1986

Edmund J. Mihalski, C.P.A.
Deputy Chief of Staff
for Health Policy
United States Senate
Committee on Finance
Washington, D.C. 20510

Dear Mr. Mihalski:

In response to Senator Packwood's question, differences in receptivity to the swing-bed approach in the 5 states included in our demonstration related primarily to nursing home occupancy and availability in a given area and to state medicaid reimbursement. Where nursing home beds were unavailable and hospital reimbursement for swing-beds adequate, there was receptivity to the program.

Swing-beds are most appropriate in those areas of the country where there are few or unavailable skilled nursing home beds, where hospital occupancy is low and where there is a high elderly population. Rather than being an alternative to "distinct part" nursing home units in hospitals, swing-beds should exist side by side with distinct parts for those five to ten patients on any day who can occupy beds for long-term care in acute care patient units.

Please contact me if you wish further information.

Sincerely,

Tony Kovner

Anthony R. Kovner, Ph.D.
Program Director

ARK:jb

TESTIMONY

Before the
FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH

on

RURAL HOSPITALS UNDER THE MEDICARE PROGRAM

by

JEFFREY C. MERRILL
The Robert Wood Johnson Foundation

May 9, 1986

Introduction:

Between 1980 and 1984, 61 rural hospitals in closed. However, by the end of this century, it is estimated that 600 of the approximately 2700 rural hospitals are projected to close. Many others are also reporting financial distress. While less than half of all hospitals report operating deficits, almost two-thirds of rural hospitals have negative margins.

In part, this testimony will describe why current conditions may make future closures more likely. Additionally, the testimony will suggest some possible approaches to improving this current trend.

Background

Rural hospitals represent less than half the hospitals in America. However, because most of them are small — 94 percent have fewer than 200 beds and 72 percent have fewer than 100 beds — they represent only one-fourth of this nation's total in-patient capacity. Nevertheless, for almost 95 million Americans, these facilities serve as a major source of health care. In fact, many of these rural hospitals are the sole providers of care in their communities.

Additionally, rural hospitals are often the first or second largest employer and purchaser in the area. The rural hospital also helps local economies by making a community attractive for businesses that may not want to locate in areas with accessible health care for their employees. Physicians are more likely to settle and remain in communities with hospitals than in communities without hospitals. Thus, the rural hospital plays a significant role, both as a health care provider, and as an important factor in the overall economic well-being of many communities.

The Problem

Rural hospitals have never been totally secure financially. Declining rural populations, high standby costs resulting from lower occupancy rates, and difficulty in attracting adequate manpower increasingly plagued the financial viability of these institutions during the 1970s. An informal HCFA study done in 1980 showed that the majority of hospitals in this nation with negative operating margins were rural hospitals. Public urban facilities were the only other group to share this level of financial distress.

Yet, the problem has deteriorated considerably since then. As with most public policy issues, there is no single cause of this accelerated decline. Rather, the problems are complex and interrelated. They involve both changes taking place throughout the health system and factors peculiar to rural hospitals. I would like to summarize what I would consider the major factors that have put rural hospitals at risk in today's health care environment:

1. Declining Utilization: Between 1980-84, all community hospitals have had fewer admissions and lower occupancy rates. But the decline in these measures was greater for rural hospitals:

   o discharges from the hospitals declined 2 percent for all U.S. hospitals but 17 percent for rural hospitals;

   o in 1984, occupancy rates averaged 69 percent for all U.S. community hospitals, relative to 75 percent in 1980; in rural hospitals, the average occupany was 60 percent, relative to 68 percent in 1980. For the nearly 1000 rural hospitals with fewer than 60 beds, the average occupancy rate in 1984 had dropped to 41 percent.

Thus, while declining occupancy rates represented a problem for hospitals throughout the nation, it was particularly problemmatic for rural hospitals. Not only were the declines more dramatic, but they affected facilities with already lower rates of occupancy.

2. Depressed Rural Economies: The depression in many farm communities has contributed significantly to the problems confronting rural hospitals. The farm crisis has reduced local revenue bases which, in turn, has decreased these communities' ability to support their hospitals. Since 50 percent of all rural hospitals are tax-supported, this problem has exacerbated the financial difficulties of many of these institutions.

Additionally, the depressed rural economy has forced many individuals to leave and move to urban areas where employment opportunities are enhanced. This further decreases the population base for these hospitals.

This depressed economic situation has also placed many local banks in jeopardy. This has made it harder for rural hospitals to access capital both for operating purposes and for the upgrading and modernization necessary to compete for staff and patients.

Lastly, a deteriorating rural economy can lead to an increased number of people without adequate health coverage. While no trend data is available on the uninsured, the rural unemployment rate rose from 7.1 percent in 1980 to 9.2 percent in 1984. Further, in 1984, there were almost 11 million people in rural areas without health insurance. At a time when occupancy rates are already dangerously low, it appears that a large portion of those who do use hospital care may have little or no insurance to cover the cost of that care. This places even greater financial stress on many of these hospitals.

3. Increased Competition: As larger hospitals in urban areas face declining utilization, they are attempting to increase their market share into rural areas through advertising and setting up satellite clinics. Improvement in the nation's highways has often made the larger facilities more accessible to rural populations. Also, an inability on the part of many rural facilities to attract sufficient manpower and to raise capital to modernize has made them even more vulnerable to competition from urban hospitals.

While it may make more sense in many such areas for the rural facilities to close, this may not always be the most desirable solution. Where the rural care can be upgraded, a local hospital may represent a less expensive and more personal form of care than its larger urban counterpart. Particularly for the elderly and the poor, without adequate transportation, access to that larger facility may be very difficult both for patients and their families. Further, the closure of the hospital can also make it more difficult or impossible to attract physicians to the area. Lastly, as mentioned before, the closure of a local facility may have an adverse economic impact on communities already facing financial difficulties.

This does not imply that all rural hospitals must be maintained. The quality of care provided, the hospital's financial situation, access to other hospitals, alternative uses for the existing facility, and the economic status of the area, all affect the decision to continue support for a rural hospital. Nevertheless, the competition from larger facilities and the improved transportation system are making such decisions more inevitable.

4. Reimbursement Changes: Recent increased pressures from public and private third party payors has also made the plight of rural hospitals more difficult. Private payors have attempted to tighten up on their reimbursement, particularly as employer pressure mounts. Medicaid has also moved away from cost-based reimbursement in many states towards more controlled mechanisms for payment to hospitals. Nevertheless, in my opinion the most significant reimbursement change that has affected rural hospitals has been the Medicare Prospective Payment System (PPS).

Although rural hospitals experienced financial difficulties prior to PPS, this new reimbursement system is of particular concern because 50-70 percent of patients in a rural hospital are typically covered by Medicare. It has been argued that, because of how PPS treats rural facilites, they are often paid 20-35 percent, and sometimes as much as 50 percent, less than urban hospitals.

As with all reimbursement approaches that attempt to respond — on a national basis — to the diverse needs of multiple types of institutions, PPS is bound to affect certain groups of hospitals adversely. In my opinion, many rural hospitals may be included in one of those groups.

While some accommodations were made in the development of PPS to acknowledge legitimate differences between rural and urban facilities, the overall effect may, in fact, have been detrimental to rural hospitals. For example, there was an implicit assumption that costs for rural facilities would always be lower for their urban counterparts. This applied to overall operations as well as to personnel. However, this may not always be the case. The higher costs of transporting goods to rural areas, the lack of opportunities for bulk or group purchasing, and the higher costs associated with lower occupancy rates all may, in fact, make it more expensive to operate a rural facility.

Further, while wage rates can be lower in many rural areas, this is not always the case. Often rural communities must draw their manpower from the same pool as urban areas and, thus, pay comparable salaries. Second, in order to even attract personnel to rural communities, higher salaries often must be offered to prospective employees.

Thus, giving special treatment to rural areas may have incorrectly assumed that the general tendencies towards lower costs were universal. While changes have occurred in PPS to correct some of this, and some retroactive adjustments have been made, the problem has not been totally addressed.

In addition, there are other, possibly more serious problems resulting from PPS: One reason many urban hospitals have done well has been the teaching adjustment to the DRG payment. While there is a correlation between higher costs and teaching status, this adjustment also serves as a mechanism to account for other, unrelated factors that increase a hospital's cost. The most important of these factors is care to the poor.

Since rural hospitals seldom have teaching programs, they do not benefit from this adjustment. They do, however, care for the poor and if, as the data suggest, hospitals with a higher percentage of the poor incur greater costs, they may be penalized under PPS. While recent legislation will provide some relief by making adjustments for rural hospitals with extremely high Medicaid populations, this may not totally solve the problem, particularly for those hospitals in states with poor Medicaid coverage. Further, while urban public hospitals benefit under this provision even without meeting the Medicaid threshold, this same advantage has not been afforded to rural, public facilities.

A last issue related to PPS concerns payment for outlier cases. While paying for costs that exceed the outlier trim points certainly ease the burden for larger hospitals, this relief may be too late for a small facility. The burden of absorbing a cost of $10-15,000 in a few cases may be enough to tilt a small hospital towards financial collapse. Further, PPS implicitly assumes that hospitals will have a sufficient number of cases so that the law of large numbers will be in effect: That is, for every case where the hospital loses under PPS, the probability is that there will be another case where the DRG payment will exceed the costs. For a hospital with many fewer discharges, the law of large numbers is not applicable. It is possible that, in a given year, a hospital may have the vast majority of its cases cost more than the DRG payment. This may be particularly so given the lower rural reimbursement rates and the lack of the favorable teaching and Medicaid adjustments discussed above.

Some Solutions

Clearly, then, rural hospitals are confronted with a series of problems, each of which may not be sufficient to create a crisis. However, in combination, they may represent a burden that places the future of rural hospitals in some jeopardy.

One might argue, and there would be considerable justification for such an argument, that we are dealing in the marketplace and, if some hospitals just cannot survive in the current environment, so be it. Further, many rural facilities have had difficulties in attracting qualified manpower, and maintaining a modern facility that reflects current medical practice. Thus, an argument can be made that facilities who cannot provide high quality care should not remain open.

These are well-justified points of view. Nevertheless, there are some facilities who represent the sole or major access point into the health care system. To let these close might respond to market forces, but may not be in the best interests of the community they serve. Second, this is not necessarily a binary choice between closure and continued operations at current capacity. Facilities can be downsized, converted to alternative use, or merged with other facilities as part of a regional system. Thus, there are clearly intermediate choices short of closure. Thirdly, if it is deemed that a hospital should continue to exist, and quality is a problem, then a major priority must be to upgrade that facility in terms of plant, equipment, and manpower.

As with the causes of the problem, there are also no simple solutions. Further, whatever the solutions, the rural hospital system in the year 2000 will look different from what exists today. Closures, mergers, regionalized arrangements, greater diversity of services and different financing approaches will greatly alter the current array and operations of rural hospitals.

Lastly, it should be clear that rural hospitals have not been passive about their current plight. A number of exciting and innovative initiatives are being attempted to address the problems they

For example, in North Dakota, rural hospitals have formed a consortium to regionalize services more appropriately among the facilities. In North Carolina, a rural hospital has been negotiating with a large urban facility to provide needed physician training and services. In return, that rural facility would drastically reduce its bed complement and refer more complex cases to the urban hospital. In Kansas, the state hospital association is providing a team of consultants to help rural facilities determine their financial viability and to develop specific plans for the future. These are only examples of the considerable activity going on around the country.

I would like to devote the remainder of my testimony to some suggestions for the types of activities that might enhance the future of rural facilities. Generically, any efforts of this kind must assess need, ensure financial stability, increase cost-efficiency, and improve the quality of care. In my view, three general strategies are possible. They include: (1) improving organizational arrangements; (2) enhancing cost-efficiency; and (3) expanding and diversifying revenue bases.

(1) Improve organizational arrangements: Rural hospitals can be strengthened by forming linkages with other hospitals, either through regionalized systems of care or through affiliations with large urban health centers. Regionalization can take two basic forms: (a) merger and closure where a group of facilities might consolidate their operations at one facility, possibly using the other hospitals as satellites to provide, for example, out-patient or long-term care; or (b) the allocating of services among the hospitals so that one hospital might provide in-patient pediatric care while another might be the

regionalized provider of emergency medicine. Both forms of regionalization might result in reductions of unnecessary capacity and redundant services, increased cost-efficiency, and improved quality due a to concentration of the available expertise. Affiliation with large academic medical centers could result in many of the same improvements. Further, by rotating specialists from the affiliated medical center through rural hospitals and, in turn, promoting referrals to the tertiary-care institutions, the quality of care would be enhanced. A combination of regionalizing services among rural hospitals and then affiliating that system to an urban center might also be possible

(2) Promote cost-efficiency: Related to efforts to streamline organizational structures are strategies to enhance efficiency through improved management, mergers, closure and/or conversion, and reductions in facility size and services. These steps can, of course, be taken by individual institutions independent of regionalization or affiliation.

Another strategy for increasing cost-efficiency is the promotion of shared services, purchasing, or data systems. Sharing a mobile CT scanner, establishing a common billing system, and arranging for joint purchasing of medical supplies are all proven methods of cutting costs that could be more widely utilized by rural hospitals.

(3) Expand revenue bases: The hospital is often in the enviable position of being the only institution in a rural area with the potential to provide needed health and health-related services. The provision of such services can expand its revenue base. For example, in our Foundation's swing-bed and hospital-based long-term care

initiaties programs, diversification of services has already proven effective in both providing needed services and expanding revenues.

In both these programs, the expansion was in terms of long-term care services. Hospitals might also provide a broader array of preventive, ambulatory or rehabilitative services that would enhance their revenue base. Further, hospitals might branch out of health care and use existing capacity to provide hotel, food, laundry, maintenance, etc. services as well.

Another means of strengthening a rural hospital's financial status is for it to establish a market niche either independently, or, preferably, through regional agreements. For instance, if a hospital chose to upgrade obstetrical equipment and personnel, it might be able to "corner the market" in a rural region, thereby improving its quality of care and even subsidizing other less profitable services.

Finally, rural hospitals may wish to consider forming capitated systems. This may create new markets, stabilize cash flow and enhance revenues. As an example, in Wisconsin, a rural hospital cooperative has successfully marketed an HMO which uses the member hospitals as its providers. This cooperative has, incidentally, incorporated many of these other strategies. It has rationalized acute care services throughout its system, diversified into long-term care and supportive services, and instituted uniform billing, shared services, and joint purchasing for its members.

Summary

The Robert Wood Johnson Foundation has and continues to be interested in promoting rural health care. In the past, we have supported efforts to train primary care manpower and encourage the development of rural systems to place that personnel. As Dr. Kovner will describe, we have promoted the dissemination of the "swing-bed" concept to rural hospitals. We are now supporting efforts in Kansas to explore approaches to improving the financial viability of rural hospitals in that state. Finally, we are now exploring some additional ways to further assist rural hospitals throughout the country in achieving greater financial stability and improving quality. However, no final program has been formulated.

Whatever we, or all Foundations, can accomplish is only part of what needs to be done. While the current budgetary concerns may preclude any new major Federal role, it is important the Federal government assures that inequities are not perpetuated under current financing mechanisms. Certainly, progress has been made with regard to PPS but, to date, not all the problems have been acknowledged or solved.

Lastly, rural hospitals must be made aware of what possibilities exist for improved financial viability, and the technical capability should be made available to them to assist in carrying out their plans. As a footnote, in our own exploration of this problem, we determined that a large number of hospitals might be offered technical assistance for a relatively small investment. For example, to provide consultation and some start-up subsidies, between 100 and 200 hospitals might be helped for less than $10 million. This assumes that groups of facilities will work together to achieve mutual solutions. Thus, even a modest Federal effort might benefit a substantial number of institutions.

In conclusion, I do believe that we can start to address this issue in meaningful ways. However, this will require that the necessary infomation and expertise is made available to hospitals, that they receive equitable treatment through the reimbursement system; and that we recognize that this is not simply a problem of health care in some small communities, but is a problem that affects almost half of our citizens and is related to the overall economic well-being of our nation.

Senator **Durenberger**. Dr. Kovner.

STATEMENT OF ANTHONY R. KOVNER, PH.D., PROFESSOR AND DIRECTOR, PROGRAM HEALTH POLICY MANAGEMENT, NEW YORK UNIVERSITY, NEW YORK, NY, SENIOR PROGRAM CONSULTANT, ROBERT WOOD JOHNSON FOUNDATION

Dr. **Kovner**. Thank you. Swing beds are hospitals beds that can be used for acute care or for long-term care and were developed where you have a situation of hospital overcapacity and yet, a shortage of long-term care, especially, skilled care.

As was reported, over 700 small rural hospitals have implemented swing beds, but, that is only half of the small rural hospitals. I think part of the problem is what Senator Durenberger referred to as lack of coping capacity, for very small, often isolated institutions.

We been running a demonstration program with 26 hospitals in five rural States and we have come up with the following conclusions about swing beds.

First, they can definitely improve access to long-term care in rural areas. They can help the financial status and survival of small rural hospitals. We are talking here about something like $100,000 a year or 6 percent of revenues. It is not enough to save a struggling hospital, but, it can make a contribution. Swing bed services can be implemented by most small rural hospitals without financial abuse and with the cooperation of local nursing homes. Swing beds can improve patient care for all elderly patients in the hospital, not only for the long-term care patients and provide rehabilitation services within the community.

The Swing Bed Program is obviously not a total answer for the elderly's long-term care needs or for the survival of rural hospitals. The problems are too large for one limited and specific program to solve. However, swing beds should remain an essential part of national rural health policy and be made available in larger rural hospitals and in all hospitals. as part of a national long-term care policy.

Thank you.

[The prepared statement of Dr. Kovner follows:]

Statement of Anthony R. Kovner, Ph.D.
Before the Subcommittee on Health of the Senate Committee in Finance
On Rural Hospitals and Swing-Beds

May 9, 1986

My name is Tony Kovner. I am a Professor at the Graduate School of Public Administration at New York University and Director of the School's Program in Health Policy and Management. I am also Senior Program Consultant to The Robert Wood Johnson Foundation and have been directing for The Foundation since 1981, the Rural Hospital Program of Extended-Care Services, otherwise known as swing-beds.

Program Background

In the early 1970s, many rural areas lacked sufficient extended-care services, particularly those provided by skilled nursing homes, to meet local care needs. Local nursing homes were often characterized by high occupancy rates and waiting lists for admissions. Families became separated when patients had to be admitted to nursing homes many miles from their homes.

At the same time, the occupancy rates for many rural hospitals were declining because of a shrinking population base, inadequate physician supply, and loss of patients to referral centers in urban areas. This decline in rural hospital occupancy combined with the shortage of extended-care beds in rural areas led the federal government to sponsor an experimental program to determine whether hospital swing-beds could offer a satisfactory response. From 1973 to 1981, a total of 108 rural hospitals in Iowa, South Dakota, Texas and Utah participated in this federal demonstration, which was evaluated by the University of Colorado Health Sciences Center.

The evaluators recommended the implementation of a national swing-bed program based on these major findings:

- an unmet need for extended-care services existed in many rural communities.

- the provision of long-term care in existing rural hospitals was potentially more cost-effective than other alternatives in meeting the demand for extended-care services.
- patients and families benefitted when patients stayed in their communities for nursing home care.
- rural hospitals could improve their financial condition through providing swing-bed services.

Primarily because of this experimental effort, Congress enacted the Omnibus Reconciliation Act of 1980, allowing Medicare and Medicaid payment for swing-bed care in rural hospitals if they had fewer than 50 beds, had received a certificate of need (if required by the state); and, had made provision to provide social services, patient activities, discharge planning, and special rehabilitation services to their long-term care patients. The hospitals are paid at the average rate per day that the given state's Medicaid plan paid last year to nursing homes for routine services. Ancillary services are billed separately on a cost basis.

The Congress, however, did not provide support for hospitals to have access to education and technical assistance for meeting the special nursing care and administrative requirements that can be barriers to implementation of a swing-bed program. The Rural Hospital Program of Extended-Care Services (Swing-Bed) of The Robert Wood Johnson Foundation (RWJ), co-sponsored by the American Hospital Association, was planned to meet this need.

The program has had four objectives. The first is to create an awareness and understanding of the opportunity afforded by the swing-bed provision of Medicare and Medicaid reimbursement. A second objective is to assist a number of small rural hospitals to show how the swing-bed concept can be successfully implemented.

Thirdly, by working with state hospital associations, the program seeks to assist in developing capabilities for technical assistance in close proximity to the small rural hospitals. And finally, the Program was designed so that the knowledge gained by its participants can be shared with others to further implement the swing-bed concept nationally.

The Grantees

26 hospitals received funding: 6 were in Kansas and 6 in New Mexico, 5 were in Missouri and 5 in North Dakota and 4 were in Mississippi. By the time the grant was made and before payment could begin, each hospital had to meet Medicare and Medicaid conditions of participation. Once certified, the hospitals could use grant funds for the following purposes:

- Training and salary assistance to replace staff being trained;
- Salary assistance for staff to provide specialized services such as physical therapy;
- Recruitment of volunteers;
- Implementing a system for quality assurance;
- Public education;
- Physical therapy and rehabilitation equipment (up to $10,000).

Grant funds could not be used to replace existing budgets for services to the chronically ill, or reimbursement of direct patient services, or for the construction or renovation of facilities.

Data from the Demonstration Hospitals

Swing-Bed Utilization

Patient Days: The grantee hospitals experienced a 20 percent decline in acute care patient days from 1983 to 1985. The influence of swing-bed patient days on total patient days, therefore, has become increasingly important. In the first quarter of 1983, swing-bed patient days were 3 percent of total patient days. In the first quarter of 1984, swing-bed patient days had become 19 percent of total patient days. By the first quarter of 1985, the percentage that swing-bed patient days represented of total patient days had grown to 26 percent.

Occupancy Rate: Between 1981 and 1985, the acute care occupancy rate dropped in the grantee hospitals in every state. In 1981, the acute care occupancy rate ranged from a low of 43 percent in Missouri grantee hospitals to a high of 50 percnet in the Mississippi grantee hospitals. By the first two quarters of 1985, the acute care occupancy of the grantee hospitals ranged from a low of 20 percent in Kansas to a high of 33.6 percent in Mississippi. However, when swing-bed patient days are counted, the total occupancy range increases from a low 34.7 percent to a high of 51 percent in those two states.

Average Length of Stay: The average length of stay (ALOS) for skilled and intermediate swing-bed patients in the grantee hospitals, has remained fairly constant. At the end of the 1984 grant year the ALOS was 21.2 days and it fell slightly to 19.8 days during the first quarter of 1985.

Swing-Bed Admissions: Since average length of stay has remained relatively stable, the increase in swing-bed patient days is largely accounted for by the steady growth in swing-bed admissions. In the first quarter of 1983, there were a total of 98 patients or an average of 4 patients per grantee hospital admitted for swing-bed services. In the first quarter of 1984, the total of swing-bed patients admitted had quadrupled to 394 patients or an average of 15 patients admitted for swing-bed services in each grantee hospital. The growth in admissions has continued. In the first quarter of 1985 there were 522 total admissions or an average of 20 swing-bed admissions per hospital.

Swing-Bed Patient Characteristics

The characteristics of the typical patient who has used swing-bed services over the duration of the program has remained relatively unchanged. The patient is a white, female widow who is 75 years or older and requires a skilled-nursing level of care which is covered by Medicare. The patient is admitted initially to the hospital from a private residence where she has been living alone or with family members. The most common reason for admission to acute care is a fracture or a stroke. During their swing-bed stay, about half of the patients receive physical therapy. Upon discharge, there is slightly more than a 50 percent chance that the swing-bed patient will return to live alone or with family members; a 23 percent chance that the patient will be discharged to a nursing home. Readmission to an acute level of care occurs about 11 percent of the time. About 10 percent of the patients die while at a swing-bed level of care. The final 4 percent have other living arrangements.

Reimbursement for Swing-Bed Services

The hospitals in the demonstration have been paid for routine swing-bed services, as stipulated in the authorizing legislation, using a per diem rate based on the average state Medicaid skilled or intermediate care rate for the previous year plus the reasonable cost for ancillary services. The average skilled and intermediate rates in 1985 range from a low of $35.87 to a high of $69.71 for skilled care and, for intermediate level care, a low of $28.62 to a high of $43.03. Grantee hospitals report that ancillary charges average between $25 to $50 per swing-bed day.

At the end of the second quarter of 1985, 64 percent of the swing-bed patients were covered under Medicare, 17 percent were self-pay, 11 percent were Medicare with Medicaid paying the co-insurance required from the 21st day of post-hospital skilled care, and 6 percent were covered under the state's Medicaid plan. The remaining 2 percent of the swing-bed patients were covered by other insurance or pension plans. The combined Medicare and Medicare/Medicaid swing-bed patients accounted for 81 percent of all patients, making the swing-bed program in the grantee hospitals largely a Medicare program.

The financial impact on the hospitals has not been fully documented largely because the cost-accounting methods used in the hospitals cannot adequately identify the incremental cost associated with swing-bed patient care. In the few hospitals where there has been an attempt to isolate the costs of swing-bed services, it has been found that the introduction of the swing-bed program did bring in additional revenue that had an overall positive impact on hospital operations by reducing deficits or slightly increasing a surplus. For example, during the first quarter of 1985, the average grantee hospital had 1,570 swing-bed and 4,500 acute patient days for a total of 6,000 patient days. The revenue for each swing-bed patient day was, on average, $87 - $47 for routine services and $40 for ancillary charges. This would provide a total of $136,598 in annual swing-bed revenue. Assuming total hospital revenue is $2.25 million, at $375 per day for $6,000 days, swing-bed revenue is roughly 6% of total revenue. The revenue estimates vary depending on the volume and patient mix of both acute and swing-bed patients.

Hospital Participation

As of January 1, 1986, approximately 770 or about 50 percent of the 1400 to 1700 hospitals eligible (depending on the definition of eligibility) to participate in the swing-bed program had been certified by Medicare. The certified hospitals are in 39 states.

At a recent conference for state hospital associations to discuss hospital participation and other swing-bed issues, the major findings were:

- The hospital association can play an important role in promoting the swing-bed concept and in providing assistance to hospitals that plan to implement swing-bed services.
- State level regulatory problems for certification and reimbursement, do exist in many states, but these can be minimized through technical assistance from the hospital association.
- Opposition from the nursing home industry can occur at the state level, but has not been a major problem at the local level.
- The swing-bed program is primarily a program for meeting the extended care needs of the rural elderly.
- The swing-bed program cannot, on its own, save a failing hospital but it can provide revenue to help a hospital survive.
- Swing-bed services often function as a "springboard" to other areas of diversification for small, rural hospitals and can help them move out of their traditional acute care role.

We think that swing-beds can best be understood by looking at specific examples. I will present 3 case studies of the impact of the program on hospital services and finances and the elderly.

Cedar County Memorial Hospital: Impact on Patient Care Services

Cedar County Memorial Hospital, a 34 bed facility in El Dorado Springs, Missouri, is a good example of how the implementation of a swing-bed program can help to:

- make the hospital staff more sensitive to the needs of the elderly acute as well as long-term care patients;
- make new specialized services available for all hospital patients;
- develop new methods of working together among hospital staff members.

Staff Sensitivity to Elderly Patients

The inservice educational programs provided as orientation to nursing and other staff at Cedar County Memorial have emphesized the psychosocial needs of the elderly. As a result, the nursing staff has changed some of the ways they care for elderly patients, whether they are acute or long-term. For example, instead of "doing everything" for patients as is frequently the approach for short-term acute stays, the staff now takes the additional time necessary to allow acute many patients to dress and feed themselves. Also, the staff is taking more time to involve the family with the patient's care. Instead of considering the family as only visitors, the staff now views the family of acute and long-term care elderly patients more as adjuncts to their own plan of care for the patient. The staff teaches the family members proper and safe techniques for helping patients make the transition to home easier.

Availability of New Services to All Patients

For most small, rural hospitals, the introduction of swing-bed services means the introduction of special services required by the conditions of participation - physical therapy, social services, patient activities and discharge planning. Cedar County had a physical therapist and social worker at the time the swing-bed program began. With swing-bed funding this hospital was able to add speech and occupational therapists. However, none of these services were used extensively for acute patients until the physicians had experience with them in the swing-bed program. Now physicians routinely refer acute patients to the social worker for discharge planning, and use rehabilitative services for all patients at a greater rate.

New Ways of Staff Working Together

Swing-bed care requires that nurses and specialized staff take more responsibility for patient care and the physician becomes less involved in the daily monitoring of the patients. Physicians, for example, do not always visit the long-term care patients daily and must rely on the assessment and observations of the nursing staff in detecting changes in the patient's status. The physicians and nurses depend on the physical therapist's evaluation of the patient's functional level and progress and on the social worker's planning for timely and appropriate discharge. The sharing of information through documentation on the patient's chart as well as informal discussions has increased communication and cooperation and engendered a mutual professional respect among all hospital staff.

District II Community Hospital: Impact on Hospital Finance

District II, a 29 bed hospital in Durant, Mississippi provides an example of the direct and indirect ways that the swing-bed program can help a hospital through a period of financial and organizational crisis.

In January, 1983, when the grant was awarded to District II hospital in Durant, Mississippi, it was a 29 bed acute care hospital with an average daily census of 13 patients. The hospital was supported by gross revenues of $400-500,000 and a $28,000 annual subsidy from the county. One year later, in January 1984, the hospital had gone from a surplus of $34,000 to a deficit of $600,000 due to poor fiscal management by a new administrator.

The implementation of the swing-bed program in January 1983 was a major factor in improving the hospital's situation, although there were other managerial and organizational changes that also contributed to improvement in the hospitals status. Looking just at the swing-bed program, it had both a direct and indirect impact on the hospital:

Direct Impact

- Increased hospital occupancy: The swing-bed program got off to a slow start in 1983 with the first swing-bed patient not admitted until October. However, the program began growing after the renovation was completed. Throughout 1984 and the mid-point of 1985, there has been an average daily census of 6 swing-bed patients. Since 1984 swing-bed patient days have ranged from 38-40% of total patient days at District II.
- Increased Revenue: During the 2 1/2 years of the swing-bed program (January 1983 to June 1985), the hospital generated approximately $252,000 in revenue from the swing-bed patients. Of this amount, $154,000 was from routine charges and $98,000 from ancillary charges. Swing-bed revenue is expected to increase to $150,000-200,000 of the hospital's total annual revenues projected at one million dollars.

Indirect Impact

- Better utilization of staff: The acute care hospital is required to maintain staffing levels regardless of the number of patients. In

July 1984, when the hospital's acute care census declined to 3 patients and there were 6 swing-bed patients, the administrator was able to staff for the total 9 patients with three additional employees per day. In July 1985, when there were 2 acute care patients, swing-bed patients increased the staffing needs by 4-6 people a day. Thus, District II has been able to avoid the additional lay-offs that many small, rural hospitals have had as their acute patient volume drops.

- Improved Physician Recruitment: In the hospital's continuing attempt to recruit new physicians, the swing-bed program has been what the administrator describes as a "carrot". The physician knows the program will provide an option to discharge patients in areas with a nursing home bed shortage and keep the patients under their supervision for the additional days of care they need. Also, the swing-bed program has brought with it rehabilitative services that physicians like to have available. In general, the program increases the physicians' trust that the hospital will survive.
- Improved Community Relations: The swing-bed program provided the hospital with an opportunity to use newspapers, television, open houses and public speaking for promotion of the program and, at the same time, enhanced the public's perception of the hospital. A recent community survey revealed a dramatic improvement in the perception of the quality of care provided in the hospital. Also, the general public has recognized that the swing-bed program has helped keep personnel employed at the hospital and has not only helped the individuals but the economy of the town.

Benefits to the Swing-Bed Program to Patients

By far the major benefit of this program has been to the rural elderly patients who have been able to receive a range of long-term care services in their communities and either have avoided transfer to nursing home long distances from their families and friends, or have been able to make an easier transition to long-term institutionalization. The following two patient case studies illustrate these two potential outcomes.

Swing-Bed Patient Case Study #1

> Mr. M was a swing-bed patient at Tallahatchie General Hospital in Charleston, Mississippi, a 45 bed hospital with a distinct part. He was 76 years old when he was referred from a larger hospital's intensive care unit, a result of an acute myocardial infarction (MI). One week after admission to the larger hospital, Mr. M had coronary bypass surgery. Post-operatively, it was discovered that he had a cardio-vascular accident during surgery. At this point Mr. M did not respond or move any part of his body.
>
> As a lifelong resident of the local town, the patient's family wanted to move Mr. M back home where he could receive therapy and recuperate until arrangements could be made for nursing home placement. Upon admission to the swing-bed program, Mr. M had a naso-gastric tube, continuous oxygen, and lung congestion which required suctioning. He was aphasic and responded with nods only occasionally. He required total nursing care.
>
> The physical therapy department began immediately working with Mr. M and within days he began getting stronger, the oxygen was discontinued and he began recognizing familiar faces of family and staff. He started speaking and expressed how grateful he as to be "home at last." Three weeks after admission to the swing-bed, the naso-gastric tube was removed, Mr. M expressed a strong desire to eat. Consequently, he was started on a soft diet.
>
> Mr. M continued to have left side paralysis, but began adapting to his disability. The plan to discharge changed from nursing home placement to home with family with home health care. In the attending physician's last progress note he said, "This man has made a phenomenal recovery." The hospital staff strongly believe that the main element of this man's recovery was the fact that he was able to return to the local hospital around the people he has known and the town he has always called home.

Thus, Mr. M, illustrates how the availability of a full range of skilled nursing services, particularly an intensive rehabilitation program, can benefit the patient in two major ways: (1) by avoiding transfer to a nursing home outside the community; and (2) by facilitating recovery near home where family can be closely involved with the patient's care.

Swing-Bed Patient Case Study #2

> Mrs. C is a 71 year old female who had been admitted to the Scott County Hospital, in Scott City Kansas, a number of times in the past with circulatory problems that resulted in thrombophlebitis and stasis dermatitis with ulcers. During her last admission, it was also discovered that Mrs. C was diabetic. Mrs. C had no family living in Scott City.
>
> Mrs. C was approached about nursing home care after her diabetes was discovered but she refused to consider that option. She was allowed to return to her own home with the support of the home health department. It was only a few weeks until Mrs. C was once again a patient in the hospital. With gangrene, resulting in the loss of a leg. Her amputation resulted in an admission into the swing-bed program. It became more apparent to Mrs. C through her rehabilitation that she would not be able to return to her apartment.
>
> When her hospital roomate moved to a nursing home, the social service designee started taking Mrs. C to the nursing home to visit her former roomate and they sometimes stayed for a group activity.
>
> Mrs. C's response was very touching. She remarked that she didn't know the nursing home was so nice. She said it was nicer than a fancy hotel. In fact, Mrs. C thought it was too nice and she could never live some place that nice. She finally agreed to prepare her belongings for storage. She was transferred to the nursing home.
>
> Mrs. C has returned as a patient at Scott County once since her transfer to the nursing home. She was eager to return to the nursing home as she prepared for hospital discharge.

Mrs. C. is a good example of how the swing-bed program at Scott County Hopital has more than once been a vital link for elderly people who were faced with the reality of no longer living independently in their own home. The program has been available to provide the needed support as patients and their families examine their alternatives and move through the difficult transition into an institutional living arrangement.

Conclusions

We do not intend to suggest that there are no problems with the swing-bed program or its implementation. Problems which may occur in some settings include the viability of small rural hospitals, the difficulties of attracting specialized staff, the lack of funding for long-term care and gaming of the reimbursement system under DRGs.

The data and case studies that have been presented indicate the following preliminary conclusions about the demonstration:

- swing-bed services can be implemented by most small, rural hospitals without financial abuse, and with cooperation of the local nursing homes;
- state hospital associations can increase the participation and success of eligible hospitals in implementing swing-bed services through promotion and development of technical assistance in close proximity to small, rural hospitals;
- swing-bed hospitals can improve patient care for all elderly patients in the hospital and provide rehabilitation services within their community;
- swing-bed services can help the financial status and survival of small, rural hospitals during organizational and financial crisis by enhancing revenues, and by facilitating diversification.

In summary, we think the demonstration will show that the swing-bed program has the potential to provide a needed service to the rural elderly while benefiting most small, rural hospitals. It is a policy option that can work, and should be maintained. It is not a panacea for the rural elderly's long-term care needs or for the survival of all rural hospitals. The problems are too large for one limited and specific program to solve. However, I feel the swing-bed concept should remain an essential part of a national rural health policy, and, furthermore, warrants exploration as part of a national long-term care policy.

Table I

Characteristics of Grantee Hospitals, 1981
(n=26)

Hospital Characteristics	Number
Hospital Bed Size	
< 20 beds	2
20 - 29 beds	5
30 - 40 beds	6
41-50 beds	9
50 + beds	4
Occupancy Rates 1981	
25% to 40%	7
41% to 54%	14
55% to 75%	5
Ownership	
Community	8
County/City	11
Hospital District	2
Church Owned	4
Hospital Owned	1
Management	
Community	14
Hospital system	4
Church operated	6
Larger Hospital	2
Hospitals with Distinct Parts	4
Payor Mix 1981 (1 n/a)	
Medicare	
< 20% beds	2
21% to 50%	12
51% or >	11
Medicaid	
< 10%	19
11% to 29%	6
BC/Commercial	
< 20%	3
21% to 50%	20
51% or >	2

Table II

Selected Characteristics of Swing-Bed Patients in Grantee Hospitals June 30, 1985

Patient Characteristics	Percent (n = 501)
Age	
< 65 years	6.6
65 - 74 years	24.6
75 - 84 years	38.9
> 85 years	29.9
Race/Ethnicity	
White	89.4
Black	7.2
Hispanic	2.6
American Indian	1.2
Sex	
Female	57.3
Male	42.3
Level of Care	
Skilled	71.9
Intermediate	23.4
Other extended-care	.8
Source of Payment	
Medicare	60.7
Medicaid	6.8
Medicare/Medicaid	12.9
Self-Pay	16.9
Other	2.8
Residence Before Admission	
Private Residence	
alone	28.3
with family	52.1
Acute Hospital	8.0
Other Facility (SNF, ICF, Res.)	11.6
Primary Reason for Admission	
Fracture	13.6
Stroke	12.2
Neoplasms	11.8
Disease of Respiratory System	11.0
Heart Disease	9.6
Other	41.8
Residence After Discharge	
Private Residence	
alone	11.5
with family	38.6
SNF	11.3
ICF	11.7
acute hospital	11.3
other institution	1.5
death	10.5
other	3.6

Table III

Swing-Bed Reimbursement Rates by State
1985

State	Skilled	Intermediate
Kansas	$35.87	$28.62
Mississippi	37.06	29.22
Missouri	41.28	37.11
New Mexico	69.71	43.03
North Dakota	49.24	34.32

FIGURE 1

ACUTE PATIENT DAYS AND SWING-BED PATIENT DAYS IN GRANTEE HOSPITALS, First Quarter 1983, 1984 And 1985

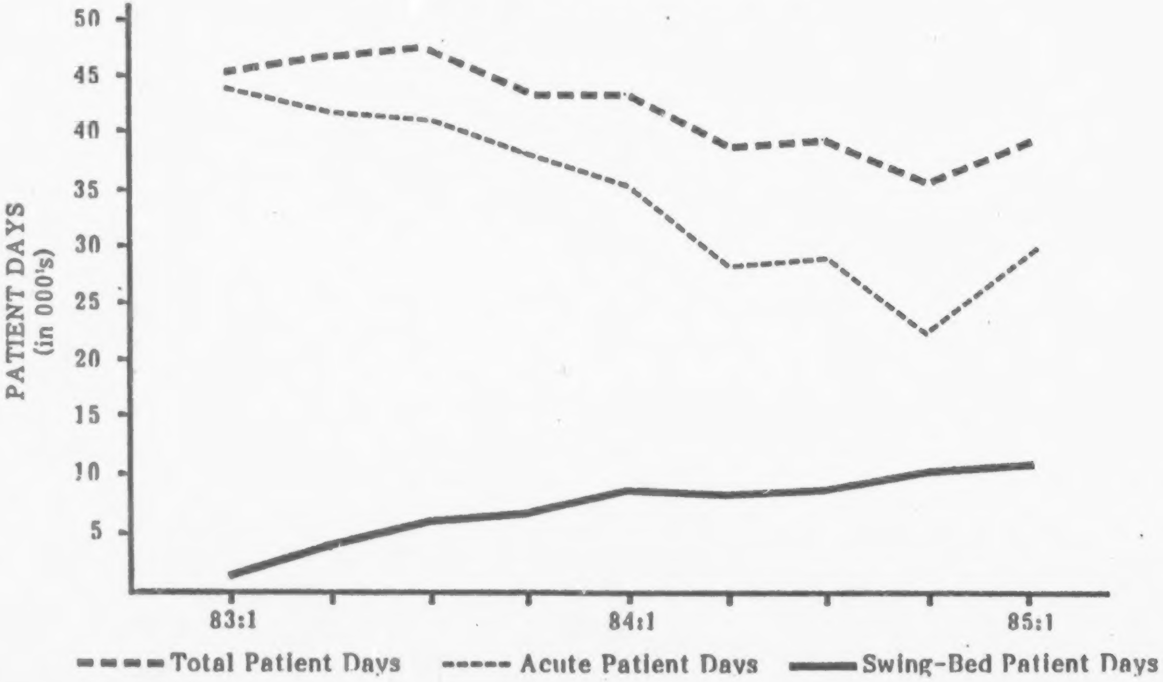


FIGURE 2

GRANTEE HOSPITAL OCCUPANCY RATE, BY STATE
1981, 1984 and Through June 1985

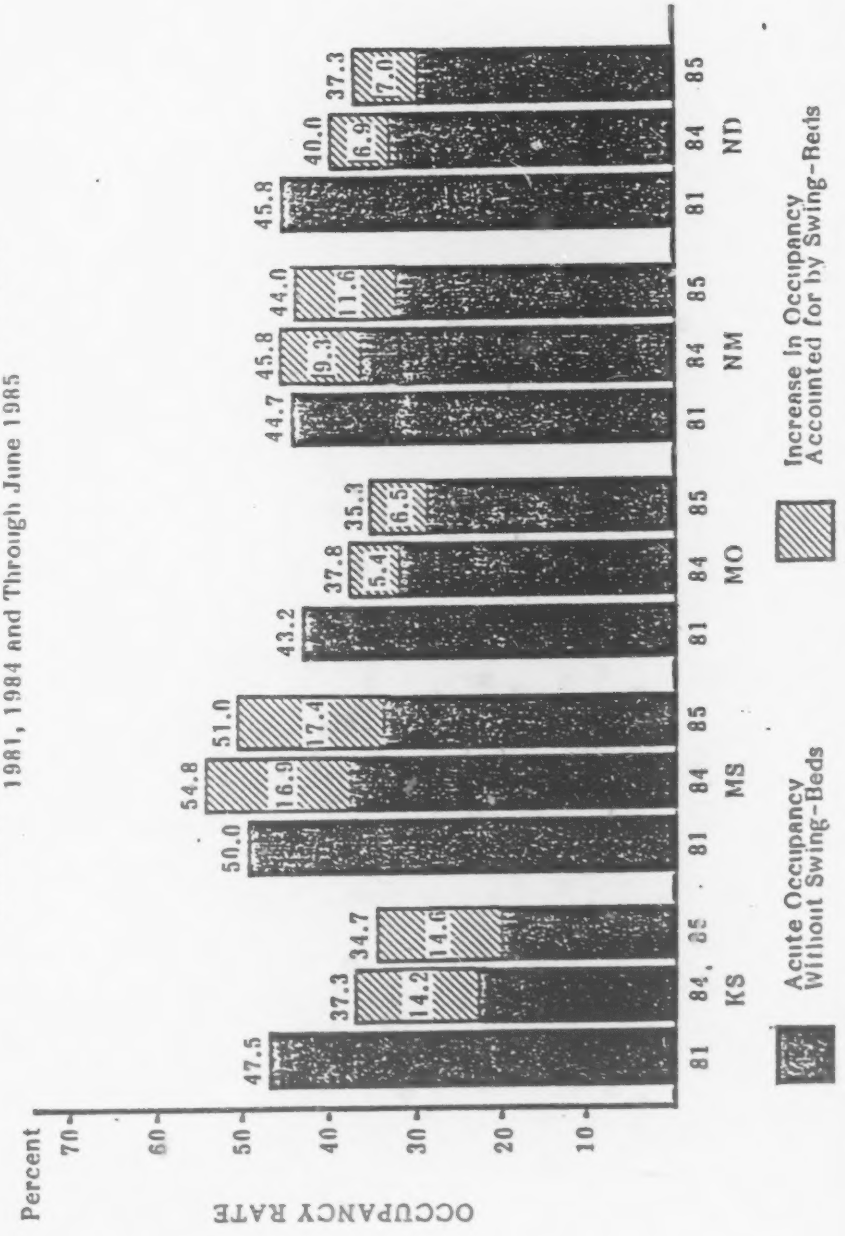


FIGURE 3

AVERAGE LENGTH OF STAY FOR SWING-BED PATIENTS - IN GRANTEE HOSPITALS
January 1, 1983 - March 31, 1985

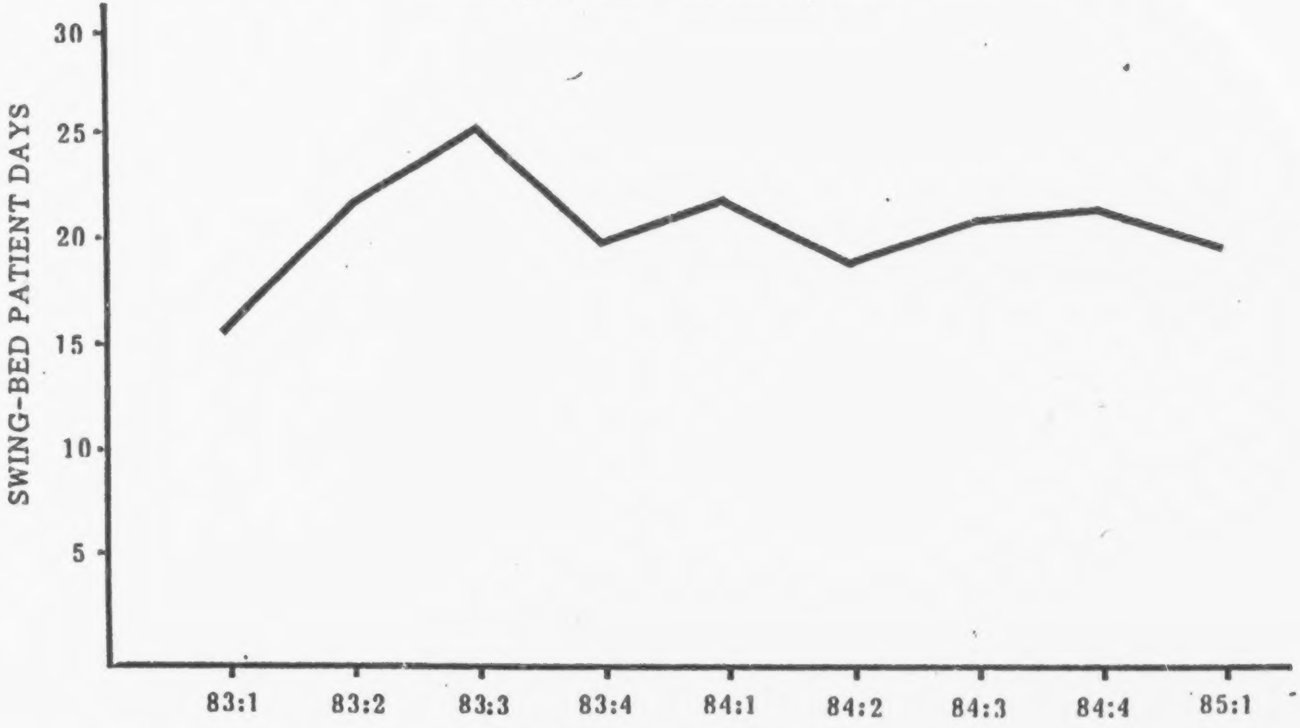
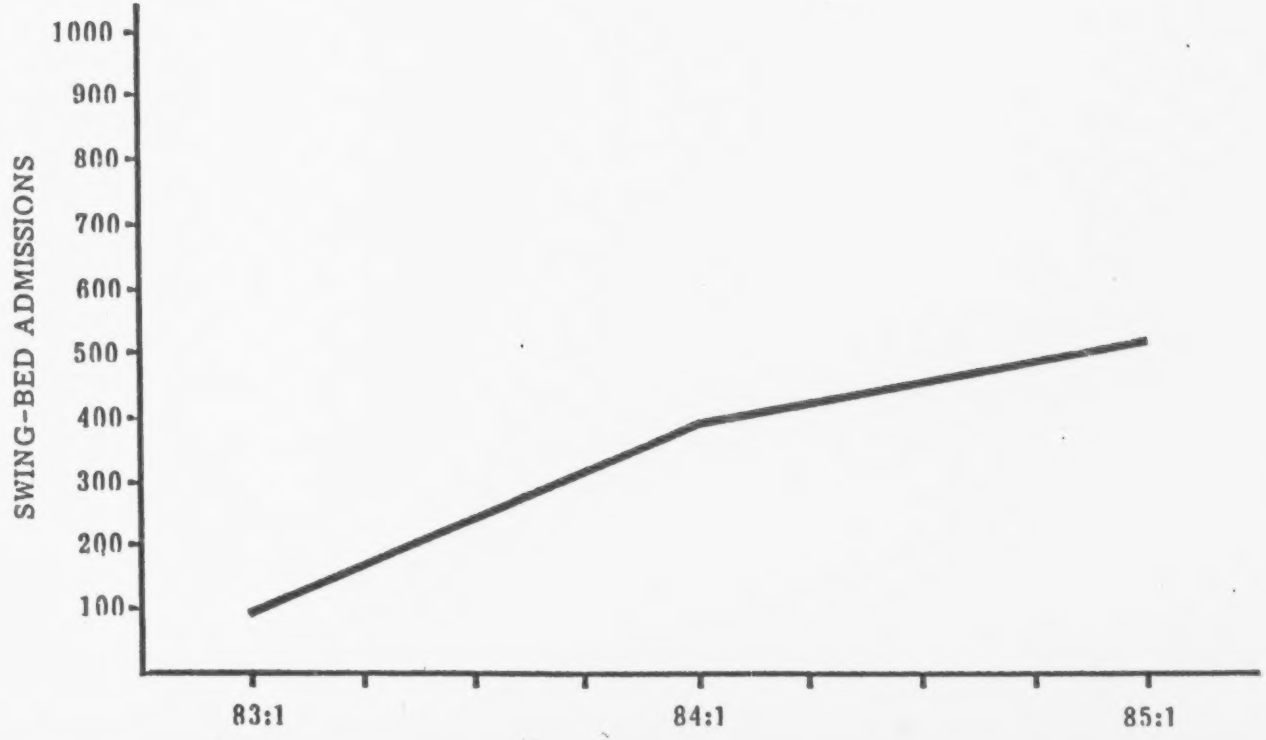


FIGURE 4

SWING-BED ADMISSIONS IN GRANTEE HOSPITALS
First Quarter 1983, 1984 And 1985



Senator **Durenberger**. Thank you, very much. I thank you all and particularly for the talent of reducing hours of knowledge, even applied to this situation, to 5-minute presentations.

Let me ask you all a question about capital and within the period of large numbers or whatever theory. We have a problem of transition. If you have a chamber of commerce and a high school, you have got to have a hospital in your town otherwise you are going to die, while everybody else lives.

One of our problems is the investment, the facility investment that we have all made in our small towns, in particular the facility investment we have made in what used to be called a hospital and now is going to be called something else. It has always bothered me that we think in terms of tax-exempt bond financing. We think in terms of capital reimbursement. Whenever we think about capital we are thinking about capital for a new hospital or a rebuilt facility or some rearrangement when it strikes me that we have needed some kind of investment for builddown not buildup.

It was a transition from what was a hospital to what will be something else. This combination that is going to occur out here and it does not seem that capital is readily available for conversion or for buy-out or buy-down the way capital is always available for a new, you name it.

I just ask all of you to comment on the nature of that problem and if you have some thought about where we ought to be making our capital investments or how we ought to be doing capital reimbursements, that would take into account that particular problem. This does not strike me to be something that I can easily write into tax-exempt bond financing or that we could easily ask the folks at HCFA to write into capital reimbursements.

Maybe, it is something that ought to bubble up to us from some kind of informal planning process, that takes place out there. You have all made reference to some of these informal arrangements that are being put together out there in communities, but how do we best look at this capital problem. Having given Joyce enough time to think about it, you have got to be first if you were first before, if you want to go first, go ahead.

Ms. **Jensen**. All right. As far as actually working with the hospitals to find capital, that is not something I do, but I do know that when we talk to them and we ask them what the problems are in putting things together that is obviously the first thing comes up.

Some people in the community often times think that rural hospitals are trying to get into things where they do not necessarily have the expertise and when they are doing that the capital is a little bit harder to find than when they are doing things for ongoing care that the community residents will benefit from.

Senator **Durenberger**. Before we go to Ira Moscovice, it is really a matter of the community, not the hospital and sometimes the community speaks through the hospital, sometimes the hospital corporation, sometimes it speaks in other ways and we get this con~~flict~~ all the time between the hospital and the nursing home. It really should not be a conflict, because we have a series of regulation and reimbursement policies for hospitals and then another one for skilled nursing and then we have another one for ICFMR and then we have something else over here for home health and it is hard for the community, however, you identify that, a town, a county, a region to speak to this issue. Ira, I guess your next.

Dr. MOSCOVICE. I think the first point I would make is that there is a true need out there for capital in rural facilities. Most of these facilities were developed under the auspices of Hill-Burton, but they have not been maintained over time. But, I do not think the answer is just to throw more dollars out there with the hope that if capital were available that innovation would occur in rural areas.

The real crux of the issue is the whole concept of leadership and attempts to keep control of the health care, social and other services in rural areas.

The Robert Wood Johnson Foundation and other groups from time to time have had innovative programs that provided some funds for hospitals that wanted to try to change their role, but hospitals have to be willing to change their role. If, they are willing to do that, then you can try to develop the capital that is necessary. That could be developed locally if the mindset of that community is willing to change, but what we are really talking about is an issue that is related to the overall notion of whether we are going to let rural areas just go down the drain.

If the economies of rural areas remain depressed, then these issues are not as important. If, we are going to try to relate health and social service delivery to the economic development issue and come forward with a plan that is going to help rural areas, then you are going to see some innovative leaders, creative people stay out in rural areas and try and change the mindset of the community. But, it is not easy to change that mindset.

So, I think the first thing is not to just raise capital for rural areas, but rather to change the way rural communities think about their future development.

Senator DURENBERGER. Jeff Merrill.

Mr. MERRILL. Just, three quick comments. Ironically. the problem of rural hospitals in terms of capital is the opposite of what it is for large urban hospitals. It is not a question of how to limit the capital of many hospitals, it is simply a question of gettig access to capital. As the farm crisis get's worse, that problem get's worse as well.

Second, just looking around the country, it appears to me that we are not talking about large amounts of capital. I am not talking about $400 million capital plans to build a major facility, we are talking about very small amounts on—and that often may be through consortia of rural hospitals that capital my be more easily accessed.

The last thing I want to mention, I was just drugging up from my memory from many years ago, there is a provision from the 1977 amendments, which gave HCFA the authority to develop closure and conversion programs to address capital in different ways. There are even some regulations that were written and were never issued, I think in the late 1970's or early 1980's. And, maybe worth taking a look at some of the thinking that went into that as ways of dealing with capital at more innovative ways.

Senator DURENBERGER. Dr. Kovner.

Dr. KOVNER. I would just like to add that I think that the physical plant exists in terms of providing health services to the community. What do the people who live in the rural area need in the way of health services and to what extent does capital fit into that? Rural people need more access to services and the amounts of money required are not that great.

Senator DURENBERGER. Well, I am—one of the things I am apprehensive about as we move into the capital amendments on prospective payment system is how we are going to impact on this particular problem in rural America and that is one of the reasons why I tried to get a feel for this profit issue yesterday from the IG as it applies to Minnesota. The reality is that, Medicare profits in rural hospitals are substantially smaller than the average of Medicare profits in urban hospitals. One of the reasons that the Medicare profits in urban hospitals are much larger is that is where the teaching hospitals are and that the teaching hospitals are making money in a profit sense. I mean, we have been pretty generous on our indirect medical education reimbursement.

Some other areas, now we have disproportionate share, and I love to read the mail that congratulates us for what we are doing on disproportionate share, but the reality is that Medicare is carrying a lot of uncompensated care in urban hospitals and it is not carrying it in the rural hospitals. Now if we move to the national average and we factor in some kind of 6.9 or 7 percent, whatever it is for capital, and yet, the capital requirements seem to be changing in the rural area, where we are either buying to change this or change that, whatever the case may be.

I worry a little about the fact that when we sit here and we are being lobbied by the hospital associations and other people on behalf of more generous capital reimbursement. We are thinking about the 500 bed hospitals, about the 1,000 bed hospitals and all the University of Minnesota with it's hugh new capital indebtedness, we are not thinking about the consequences of having to redesign the hospital delivery system in rural America. Am I wrong to be concerned about that?

Dr. MOSCOVICE. One comment I would offer is, there is a real concern here. There are certain other professionals up in the Minneapolis area, who suggested that there are going to be 10 mega systems in the health care field by the 1990's or the year 2000 and everyone else is going to get gobbled up. I am not sure we want that as a policy to really help the future of rural America. Quite clearly, probably the most attractive benefit of joining a multi hospital system is the attraction of access to capital.

In areas like Wisconsin, North Dakota, or elsewhere where rural hospitals are banding together, they are maintaining there local identity. They are improving their ability to attract access to capital and they are able to start talking to their urban counterparts on a more level playing field.

So, what is really important is to make those kinds of benefits available at least on a networking basis to rural areas, so they can maintain their own identity. I do not think the future of rural America would be improved by the development of 10 mega health systems.

Senator BAUCUS. What do you think the key is?

Dr. MOSCOVICE. It is not ten health care entities that are going to be controlling the health system in the United States. We need regional networks, we need local identification with the health care system in rural areas. When I see rural communities networking together that I think is the strength of those communities rather than competing against each other.

Senator BAUCUS. So, in your earlier statement you tended to speak against payments in Medicare on a regional basis. Now, I hear you saying regional, so long as it is small rural regional as opposed to geographic regional. Is that correct? I am not trying to put words in your mouth, I am just trying to understand exactly what you are saying.

Dr. MOSCOVICE. What I am saying is there is strength in numbers if rural areas work together, in terms of access to capital, in terms of starting to develop some kind of powerbase. Small individual rural institutions really do not have any powerbase from which to work from.

On my earlier comments, what I was referring to are the estimates that have been made that rural hospitals would be severely affected if we shift now from the existing PPS system to the one that is intended in terms of national rates. And, so I am suggesting that rather than shifting to that kind of system right away, I think we need a year to start working out the kinds of technical and philosophical issues discussed earlier.

I generally, believe that HCFA can work out the area wage index issue, that there really are numbers available that you can start looking at and not just have a simple urban-rural differential on wage indices. I believe some time is needed in terms of that transition.

Senator BAUCUS. Would the rest of the panel generally agree with that or is there anyone, who disagrees with what Dr. Moscovice just said?

[No response.]

Senator BAUCUS. Would it make sense to require that not only sole community providers, but all small hospitals with 50 beds be compensated for capital based on their proportionate Medicare mix. Does that make sense, you think?

Dr. MOSCOVICE. My initial reaction is that it makes more sense than what appears to be going on now and in fact I think what Al Dobson mentioned earlier was that this is under serious consideration in terms of moving away from the existing payment scheme. What is clear though is that rural hospitals do not have access to capital right now. They need some mechanism for it.

Senator BAUCUS. I would like to know the panel's reaction to the bill that Senator Grassley and I introduced. We have no pride in authorship. If you think there are some features that are good, I would like to hear. If you think there are some provisions that are not good, I would like to hear that too. I do not know if you all know about the bill. Let me just go through it. It requires a rural impact statement for Medicare's regulations. Second, it requires 10-percent of HCFA's research be utilized to explore rural research programs. Third, it establishes a rural health policy office in HCFA. For hospital payments, the bill requires Medicare bill payment be speeded up. Second, the outlier provision would be addressed, so that, 5 or 6 percent of small rural Medicare payments be outlier payments, which is the case and the national average in all other hospitals. Last, we are making sure that capital payment be proportionate to Medicare's share, rather than on some other basis.

Do any of you on the panel have any reactions to that, any features of that bill, one way or the other?

Dr. KOVNER. I would just worry about the study and the research portion, given the previous testimony in terms of when you are going to find out what the impact was.

Senator BAUCUS. I share that.

Ms. JENSEN. I think that the accounts receivable portion of it is very important, because with the Medicare paying later, I think that is going to cause a lot of problems. A lot of hospitals, not just rural ones, but also the urban ones are getting into a lot of problems and they are finding, like businesses, they have to collect receivables much faster.

Senator BAUCUS. Is the bill missing the mark, I mean, should it include something else that we have neglected?

Dr. MOSCOVICE. First off, let me say that being a rural health service researcher, I think it is great. I think looking at the urban-rural payment differential, really needs to be seriously considered. I am not sure from what you just said, whether we should have one payment rate or if we are going to have differential payment rates, what are they going to be based on. I think that really is the underlying problem in PPS for rural hospitals and needs to be addressed.

Dr. KOVNER. I also worry about the sole providers, who are forced to either go out of business or operate at a much lower rate of effectiveness than they would otherwise operate. I do not know of an easy answer for this problem.

Mr. MERRILL. Two comments. One, I find the law ironic, that the notion the timely, or lack of timely payments to rural hospitals are a way of meeting the deficit crisis. In essence, what it is, is borrowing from hospitals to meet the deficit crisis as opposed to borrowing on the open market.

Senator BAUCUS. The next general question is what is your reaction to Mr. Fleming's testimony, his testimony from HCFA? Several of us asked questions, he gave a statement, I just want to give you the opportunity to tell us what you think and what you agreed with and what you do not.

Mr. MERRILL. I do not think there was any response to the problems that rural hospitals face in that testimony.

Senator BAUCUS. So, you did not hear any responses.

Mr. MERRILL. No.

Senator BAUCUS. Any other reactions?

Dr. MOSCOVICE. The only thing to recognize is that these are not just problems for rural hospitals. If you speed up payment rate, there are other institutions that probably be very grateful, also.

Senator BAUCUS. Personnaly, I found your testimony very, very helpful. I want to thank you all very much. Thank you.

Senator DURENBERGER. Thank you.

The next panel consists of Gordon Russell, Hi-Plains Hospital, Hale Center, TX, and a member of the section for small or rural hospital, American Hospital Association. Dr. Kevin Fickenscher, the director of the Office of Rural Health, University of North

Dakota School of Medicine; president-elect, National Rural Health Care Association. A.E. Brim, president, Brim & Associates from Portland, OR. Curtis Erickson, president and CEO of Great Plains Health Alliance, Phillipsburg, KS. William F. Brockmann, president and chief executive officer, Caylor-Nickel Hospital, Bluffton, IN.

Gentlemen, we thank you and we will begin all of your testimony will be made part of the record and we will begin our 5-minute summaries with Gordon Russell.

STATEMENT OF GORDON H. RUSSELL, ADMINISTRATOR, HI-PLAINS HOSPITAL, HALE CENTER, TX; AND MEMBER, SECTION FOR SMALL OR RURAL HOSPITALS, AMERICAN HOSPITAL ASSOCIATION

Mr. RUSSELL. Mr. Chairman and Senator Baucus, I am Gordon Russell, the administrator of Hi-Plains Hospital in Hale Center, TX, and I appreciate the opportunity to appear before this panel and I thank you for your interest in small and rural hospitals.

The American Hospital Association has a section for small and rural hospitals and it has been my priviledge to serve on that group and act as it's chairman.

Hi-Plains Hospital is one of the 2,696 rural hospitals in the Nation. It was established in 1946 as a cooperative. It is owned by 700 farm families. We have a total of 84 beds and these 84 beds are divided into two units, 40 for acute beds and 44 for long term. We participate in the swing bed program and run our own hospital-based home health agency.

We have a loose affiliation with 27 other hospitals in northwest Texas and our financial situation fairly well mirrors the others. We have experienced changes in the last year that have seriously affecte our existence, and although we have maintained our share of the labor market, our admissions have declined from 1,516 in 1982 to a 1,028 in 1985, and we estimate that is going down to 1,000 in 1986.

Our Medicare admissions have declined from 515 in 1982 to 340 in 1985, and we estimate that is going to be 300 in 1986. Our bottom line has dropped from a positive $120,000, 111 in 1982 to a loss of $40,128 in 1985, and we are estimating a loss this year of $58,000.

The Medicare shortfall or that amount that we write off between our normal charges and Medicare payments have gone from $19,090 in 1982 to $126,919 in 1985. Hi-Plains Hospital's problems are experienced by far too many of the rural hospitals in this Nation.

When a small hospital fails, it creates problems of access for all patients, but the burden falls the hardest on Medicare patient and of course it destroys the hopes and dreams of young people, who hope to make their futures in these small communities and it gravely affects those in the retirement years and many times can have such a financial impact, that it can be a death blow to that community.

I furnished the committee with a written statement and ask that it be a made part of the records and I would like to cover just a few of the items that I covered in that written statement.

The urban-rural rate. If there was really a difference every existed for the creation for the urban-rural rate and I have some doubts about that, I personally believe they are gone and there should be a single rate nationwide. The case mix of rural hospitals is more like the urban hospital now than it was in 1982. Differences in payment should be based on the illness of the patient and not the location of the hospital.

The area wage index does not accurately define our labor market. If Hi-Plains Hospital were located 16 miles south, it would be just within an urban county and we would realize a 25-percent increase in the Federal wage portion of the DRG. Our most expensive employee, who is a pharmacist, drives to our hospital, when it is exactly the same number of miles from his home to the nearest urban hospital and I hired him from the urban hospital. So, we do compete in the same labor market.

We have different values today and we have sicker patients and we operate differently than we did in 1982. But, we have by the use of uniform rate of increase locked into place the 1982 cost differentials.

The outlier policy is being redefined. Many of our patients stay for a long time but not long enough to reach the outliers and we are being killed by bills that are $10,000 to $11,000 and that is a lot of money for a small hospital like mine. Sometimes it can mean the difference between survival or not.

Many hospitals lately have been forced to borrow money against the accounts receivable, Senator Baucus, and because of this, because of the slowdown in Medicare payments, we are delighted that the Senate bill, I think it is 2410, introduced by you and Senator Grassley addresses this issue. It has been a real problem for particularly Texans, Texas hospitals.

The American Hospital Association has a special committee working on the problems of small and rural hospitals and the section for small and rural hospitals has an ongoing environmental assessment.

The AHA is eager to work with this subcommittee, to help to ensure access to health care and create greater equity in the Medicare Program.

I appreciate it being before you and we will try to answer any questions that you might have.

Senator **Durenberger**. Well, I thank you very much for your statement.

[The prepared statement of Mr. Russell follows:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON FINANCE OF THE UNITED STATES SENATE ON THE CONDITION OF RURAL HOSPITALS UNDER THE MEDICARE PROGRAM

May 9, 1986

INTRODUCTION

Mr. Chairman and members of the Subcommittee, I am Gordon H. Russell, administrator of Hi-Plains Hospital, Hale Center, Texas. Hi-Plains Hospital is a not-for-profit institution that is located in a predominately agricultural community. It has 84 licensed beds, 40 for short-term acute care and 44 for long-term care. The hospital, which was an early participant in the "swing-bed" program, also operates a home health agency.

I appreciate this opportunity to testify on behalf of the American Hospital Association's 5,600 member institutions and 40,000 personal members. For six years, I served on the governing council of the AHA's Section for Small or Rural Hospitals, and, for one year, chaired the council. At the request of the section, the General Council of the AHA last October created a Special Committee on Small or Rural Hospital Care to study both the equity concerns of small or rural hospitals with respect to the Medicare prospective pricing system and other financial constraints that inhibit such hospitals' ability to provide needed health care services to their communities.

Complementing the work of this targeted panel are two broader AHA efforts: an investigation of the impact of the DRG-based prospective pricing system on all types of hospitals, including rural, and development of alternatives, such as a capitated model, to the DRG system.

Concerned about the adequacy and equity of payment under the existing prospective pricing system, the AHA is pleased that the Subcommittee is holding this hearing today to examine the condition of rural hospitals under the Medicare program, and commends the esteemed chairman, Senator Durenberger, and the distinguished ranking minority member, Senator Baucus, for seeking this forum.

In this statement, following a brief statistical overview of rural hospitals, I will look at two adjustments affecting such hospitals that already have been made in the prospective pricing system: in the definition of rural referral centers and in the adoption of a new "gross area wage index." I then will discuss problems that need to be resolved: in terms of the appropriateness of DRG payment, volume considerations, urban and rural rates, and the uniform rate of increase; outlier policy; and access to post-acute services, including swing-bed utilization. In addition, I will examine special treatment for hospitals that are the sole providers of care in their communities. In exploring these topics, my overriding concern is the preservation of access to quality health care in rural communities.

STATISTICAL OVERVIEW

Of 5,969 general hospitals in the United States, there were 2,696 rural hospitals (or 47 percent of the total) in 1984, the latest year for which AHA "Annual Survey of Hospitals" data are available. More than two-thirds of the hospitals had fewer than 100 beds: 182 had fewer than 25 beds; 799, from 25 to 49 beds; and 932, from 50 to 99 beds. Of the remaining, 606 had from 100 to 199 beds, and 177, 200 beds and over. Many of the hospitals with more than 200 beds serve as rural referral centers (although not all qualify for the

Department of Health and Human Services [HHS] designation); as such, they offer an extensive range of services.

In the results from the same survey, 3,670 U.S. hospitals were designated as small or rural: having fewer than 100 acute-care beds, experiencing 4,000 or fewer annual admissions, or being located outside a Metropolitan Statistical Area (MSA). Of the total, 73 percent were classified as rural and 27 percent as small urban. In 1984, such hospitals accounted for more than 50 percent of total hospitals and for between 26 percent and 50 percent of total beds in eight of the nine U.S. Bureau of the Census divisions, with Region 2 the exception:

Census Divisions	Percent of Small & Rural Hospitals	Percent of Small & Rural Hosp. Beds
Region 1 (CT, ME, MA, NH, RI, VT)	51%	26%
Region 2 (NJ, NY, PA)	33%	14%
Region 3 (DE, DC, FL, GA, MD, NC, SC, VA, WV)	59%	31%
Region 4 (IL, IN, MI, OH, WI)	55%	26%
Region 5 (AL, KY, MS, TN)	77%	48%
Region 6 (IA, KS, MN, MO, NE, ND, SD)	84%	50%

Region 7 (AR, LA, OK, TX)	74%	37%
Region 8 (AZ, CO, ID, MT, NV, NM, UT, WY)	79%	43%
Region 9 (AK, CA, HI, OR, WA)	58%	28%

Additional data show that 49 community hospitals closed in 1985, 39 of which had fewer than 100 beds. Only 1 of the 49 had more than 300 beds. The hospitals were in 23 states, with the greatest number in California and Texas, with eight each, followed by New York with six and Michigan, four. In contrast, from 1980 through 1984, the yearly average of closures was 33.

IMPLEMENTATION AND ALTERATIONS OF MEDICARE PROSPECTIVE PRICING

The Medicare prospective pricing system was implemented October 1, 1983, less than six months after the Social Security Amendments of 1983 were signed into law. The system is an enormous, and generally positive, step toward a payment system that encourages the efficient delivery of effective medical care. Because the changes embodied in the system are so large and complex, and were put in place so swiftly, implementation of the system has not been without problems for rural hospitals. Many of these problems also have been encountered by urban hospitals, although with different results because of their environments.

Some Effects

Various effects have already been examined by this Subcommittee, in hearings on hospital operating margins, deficit reduction proposals, an adjustment for hospitals with disproportionate shares of low-income patients, direct medical education, Peer Review Organizations (PROs), and prospective pricing implementation issues. As already reported, the most dramatic effect has been substantial change in hospital utilization. Hospitals report that their admissions have declined and that the complexity and severity of illness of patients they have admitted have increased significantly.

To some degree, these changes may result in higher payments if the DRG mix of a hospital increases. However, the ability of DRGs to reflect the cost of resources used in caring for patients admitted to hospitals is limited by the DRG classification methodology. Particularly in small or rural hospitals, changes in utilization and costs appear to have outstripped increases in payments. Although figures for Medicare alone are not available, overall average per-case costs in hospitals operating fewer than 50 beds rose by 14.6 percent in 1985. Because this change reflects both Medicare and non-Medicare patients, the result is a substantial deterioration in the financial position of smaller hospitals--a prediction consistent with hospital operating margin figures reported February 21 to this Subcommittee.

Two Changes

At the time Medicare prospective pricing was implemented, it was clear that refinements in the rules would be required to improve the adequacy and equity of payments to hospitals under the program and to minimize disruption of services to Medicare beneficiaries. In a program legislated and regulated so significantly, it was obvious from the onset that "tinkering" would be needed.

Rural Referral Centers

The Deficit Reduction Act of 1984 called for various refinements, including revised criteria under which a hospital could qualify as a regional referral center. Previously, a hospital could receive the referral center designation if it met very exclusive standards: bed size of at least 500 and location in a rural area or satisfaction of restrictive patient origin criteria.

The Deficit Reduction Act expanded the concept. It required a hospital to meet two mandatory criteria: having a proscribed case mix index (1.03 in 1981 or 1.09 in its first prospective pricing cost reporting period, since updated) and number of discharges (at least 6,000). It also provided for a hospital to fulfill one of three optional criteria: more than 50 percent of its medical staff composed of "specialists," at least 50 percent of its discharges for inpatients that reside more than 25 miles away, and at least 40 percent of its inpatient referrals from non-staff physicians.

Although the expanded criteria are substantial improvements, they still exclude some hospitals in rural areas that serve as referral centers. The criteria are, like the prospective pricing system, based on averages that identify hospitals whose range of services and case severity are generally higher than average for their peer group. In the short term, HHS should regard the criteria as benchmarks rather than absolutes, not only because of their inadequacy but also because of the occurrence of minor fluctuations in case mix or admissions that can shift a hospital back and forth across the limits, even though its status and higher per-case costs do not vary. In the long term, HHS should develop service-specific criteria for such centers (as well as for urban referral centers) and pay for the services they offer on the basis of hospital-specific prices. Ultimately, the solution to this problem is the development of more adequate DRGs that reduce the need for separate urban and rural rates.

Area Wage Index

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires the HHS Secretary to implement--for hospital discharges occurring on or after May 1, 1986--a new "gross wage index" included in Medicare prospective pricing regulations published September 3, 1985. The AHA has supported adoption of the new index, due to the inadequacy of the one used to adjust federal prices under prospective pricing since implementation of the system.

The old index did not account adequately for the effects of regional variations in the mix of full- and part-time employees. It also did not recognize deficiencies in MSA and non-MSA designations to define labor markets. The new index addresses the first, but not the second, problem, which necessitates a reexamination of the adequacy of MSAs and states to define labor markets. Congress recognized this need in part when it included in the COBRA provision the requirement that the HHS Secretary work with the Prospective Payment Assessment Commission (ProPAC) in studying and developing methods of adjusting wage indices to reflect hospital labor markets more accurately. Although the provision specifically targets inner-city portions of urban areas--an essential focus--expanded study is needed as well, as pointed out by ProPAC in its April 1, 1986 "Report and Recommendations to the Secretary, U.S. Department of Health and Human Services." In urging the HHS Secretary to "improve the definition of hospital labor market areas for Fiscal Year 1987," the commission states: "For rural areas, the improved definitions should account for a greater amount of the wage variation between different rural areas within each state and between states."

The AHA has been conducting analyses that document the inadequacy of the MSA-based definition and demonstrate the availability of alternative methods of defining hospital labor markets.

PROSPECTIVE PRICING SYSTEM LIMITATIONS

Although some of the changes made in prospective pricing since its inception have helped to correct some of the system's flaws, significant problems remain. The first involves application of the existing DRG system to rural hospitals.

Recently, some rural hospitals have questioned the appropriateness of DRG-based payment for hospitals serving small, rural communities. Nationally, the smallest hospitals have reported substantial losses, often related to sharp reductions in utilization. These hospitals are often the only health care facilities in their communities and are critical to the continued availablity of medical care. The questions they pose center on volume fluctuations, discrepancy between urban and rural rates, and a uniform updating factor for all types of facilities.

Volume Considerations

The DRG payment system is based on averages. For the system to work, it is necessary for a hospital to have a volume that is sufficiently large so that both its Medicare revenues and per-case costs are stable from one period to the next. While many hospitals appear to have case mixes that are reasonably stable, some hospitals are experiencing significant fluctuations in them. In small hospitals, such fluctuations are not necessarily reflected in per-case costs, although they do result in shifts in revenues.

In order for these hospitals to meet the daily costs of operation, given these fluctuations in cash flow, it is necessary for them to resort to borrowing or slowing down payment to vendors, both of which unnecessarily increase costs. It is not that these hospitals are too small to survive, but rather that the flow of expenses does not match the flow of revenues.

Urban and Rural Rates

The topic that has caused the most discussion has been the difference between urban and rural rates of payment. Because the difference in prices is based on a difference in average costs in urban and rural hospitals, it is paradoxically both reasonable and unfair. It is reasonable to the extent that it is due to significant differences in case mix that are not measured by DRGs. It is unfair to the extent that it results in arbitrary differences in payment for the treatment of similar patients. Larger rural hospitals treat many of the same types of patients treated in the average urban hospital. The costs incurred in treating these patients in rural and urban hospitals are often comparable. But the level of payment is based on the location of the hospital, not the characteristics of the patient. The real question is not whether the differential should exist, but what to do about it. In the long run, the differential should be eliminated. It can be eliminated, however, only if the defects in the system of DRGs can be eliminated or an alternative method of setting prices that is sensitive to those defects can be identified.

A difference in payment based on location is bound to be inequitable to some degree. Ideally, the payment system would establish a single payment schedule applied to all hospitals, with adjustments as appropriate only to reflect differences in wages and other input prices. Such a system is feasible, however, only if prices are based on accurate measures of case mix, costs, and input prices.

The magnitude of the cost differences between urban and rural hospitals, as well as the difference in costs between other groups of hospitals, suggests that these conditions are not being met. Although it would be inadvisable to move to a single uniform rate without correcting the problems that led to the adoption of separate urban and rural rates, it is also necessary to address the inequities created by a dual rate system.

Uniform Rate of Increase

One special problem posed by the difference between urban and rural rates that has received relatively little attention concerns the appropriateness of using a uniform rate of increase to update urban and rural prices for the effects of inflation, technology, and product changes. The price differential was based on the difference in average costs in 1982. In the three years since 1982, utilization patterns have changed dramatically. As noted earlier, small hospitals have experienced a particularly sharp decline in admissions, and this decline has been accompanied by an above-average rate of increase in per-case costs.

Anecdotally, rural hospitals have reported that one effect of PRO review has been to increase the acuity of patients who are admitted to hospitals. If true, then it is possible that the difference between urban and rural costs is declining. Applying a uniform rate of increase to urban and rural prices, however, essentially freezes into place the 1982 cost differential. Consequently, Congress should examine the extent to which product changes have occurred that necessitate corrective action and consider the establishment of a separate update factor for rural hospitals.

Outlier Policy

The inadequacy of outlier policy is possibly the most important issue posed by the current system, because it is one of the features of the system that could be readily adjusted. In urban areas, and for larger rural hospitals, outlier policy is problematic primarily due to the disproportionate number of outlier patients treated by certain hospitals. In rural areas, and for smaller hospitals, outlier policy is troublesome because of the substantial losses that can be experienced on even a few outlier cases. In both instances, the underlying cause of difficulty is the inadequate rate of compensation provided for outlier patients and the relatively restrictive definition of an outlier case.

As an example: For an average DRG, i.e., a DRG with a cost weight of 1.0, the outlier threshold for cost outliers is $13,000. A patient who incurs costs of $15,000 meets this threshold, but the supplemental payment is only $1,200, i.e., 60 percent of the difference between the threshold and the patient's estimated cost. The total payment for such a patient is the price, for the average rural hospital approximately $2,350, plus the $1,200 supplemental payment, or $3,550. The loss that must be made up by the hospital is $11,450. Given a sufficient volume, such a loss can be made up, but in small hospitals it is often not possible to do so.

One further problem that should not be neglected is the decision by HHS to use length of stay as the primary criterion for determining the outlier status of patients. Patients who not only qualify as cost outliers but also have extended hospital stays must be paid according to the per-diem length-of-stay outlier method. Often these payments are considerably less than those for cost outliers, compounding the problems created by the current cost-outlier payment method.

The problems experienced by rural hospitals are often caused by the same factors that lead to problems in urban hospitals, such as inadequate outlier payments. But in rural hospitals the problems appear more acute because the margin of safety is smaller in smaller hospitals. The law of large numbers that underlies the DRG-pricing concept simply does not hold for many of these hospitals, given the magnitude of problems with the DRG system.

Access to Post-Acute Services

A final issue involves the rural hospital's role in assuring access for its acute-care patients to post-acute health services. In view of the incentives in the prospective pricing system for efficiency in the delivery of acute health services and the criteria for PROs in reviewing appropriateness of care, there is increased emphasis on coordinating inpatient and outpatient, acute and non-acute, short-term and long-term, and hospital-based and alternative care.

One effect of the prospective system has been highlighting of the existence of many different levels of medical need both within and without the categories of "hospital," "skilled nursing," and "home health" care. This leads to the need for reassessment of the Medicare benefit, establishment of medical review criteria that differentiate between levels of care, identification of providers capable of delivering each level of care, and assurance of continuity of care across levels.

Examples of flexible approaches to providing access include swing-bed utilization and treatment of "administratively necessary days." The AHA supported demonstrations of the swing-bed concept--alternating beds between acute- and long-term care, depending upon patient and community need--in four states, including Texas, with Hi-Plains Hospital one of the demonstration sites. When swing-bed utilization was made part of the Omnibus Reconciliation Act of 1980, the AHA opposed restricting usage to rural hospitals with fewer than 50 beds. The Association supports H.R.3000, introduced by Representative Dorgan, which would extend swing-bed participation to rural hospitals having as many as 150 beds, and urges this Subcommittee to consider similar legislation.

The AHA also supports recognition of administratively necessary days. A provision on such days is included in S.2331, the Medicare Quality Assurance Act of 1986. It would require HHS to study the treatment of days spent in the hospital awaiting placement in a skilled nursing facility (SNF). It would determine the extent to which current prices include and adequately reflect the actual costs of providing these services and whether additional payments should be made for them.

Current HHS policy prohibits hospitals from issuing notices of noncoverage to inpatients who are not at acute levels of care but are awaiting placement in SNFs. As a result of the increasing scarcity of available Medicare-covered SNF services, hospitals are more often keeping patients who do not need acute care, without any additional Medicare payment.

HHS should consider ways of enhancing the ability of hospitals to furnish post-acute services while ensuring payment for any additional services hospitals provide.

PAYMENT ADJUSTMENTS FOR
SOLE COMMUNITY PROVIDER HOSPITALS

The Social Security Amendments of 1983 mandated that hospitals that are sole providers of care in their communities permanently receive a payment rate per Medicare discharge that is composed of a 75-percent hospital-specific component and a 25-percent federal component. The hospital-specific component is computed only once. It is based on a hospital's operating costs in its prospective pricing base year, i.e., FY 1983.

The amendments also established a prior special adjustment category for sole community hospitals with declining discharges: for cost reporting perioids beginning on or after October 1, 1983, but before October 1, 1986, facilties experiencing more than a 5-percent decline in inpatient discharges can receive a payment adjustment.

Both COBRA and regulations proposed by HHS in the March 10, 1986 Federal Register offer a second category of special treatment for such providers: an adjustment due to additional operating costs incurred as a result of addition or expansion of a hospital to meet community medical needs.

The AHA supports the establishment of the special adjustment option to account for added capacity, and has asked HHS to broaden the application procedure it proposes for it and to make its implementation permanent. In addition, due to the importance of the hospital-specific component in the sole community hospital payment methodology, the Association urges adoption of a mechanism to reflect changes that occur in a hospital's average cost per case for reasons related to patient care.

Because most sole community providers are small, rural hospitals with fluctuating case mixes and volumes, a per-case payment system is inappropriate as a foundation for the payment methodology. Although the AHA supports the special adjustment in the short term, it views special treatments as administratively burdensome overall, and advocates a return to cost-based reimbursement for sole community providers. Cost-based reimbursement would recognize changes in costs related to case mix, admission declines, and modifications in community demand. Given that only 326 hospitals nationwide presently have sole community status, a return to cost-based reimbursement would represent little adverse impact for the Medicare program. The AHA urges that this Subcommittee consider a legislative provision to revise the payment method.

CONCLUSION

Mr. Chairman, as I stated earlier, the AHA has a Special Committee on Small or Rural Hospital Care that has identified numerous issues facing small or rural hospitals, some of which I have mentioned today. The committee is examining these issues and plans to have preliminary recommendations this fall and a final report early in 1987. In advance of the panel's work, I have singled out certain problems that relate primarily to the Medicare program: rural referral centers, the area wage index, volume fluctuations, discrepancy between urban and rural rates, uniform updating factor, outlier policy, access to post-acute services, and payment adjustments for sole community provider hospitals.

There are additional concerns, ones that relate primarily to administrative burdens on small, rural hospitals. Paperwork can be a problem for small facilities, as can adaption of data processing systems for electronic medical claims submission to fiscal intermediaries.

When rural hospital administrators get together, as on the governing council of the Section for Small or Rural Hospitals, we talk about the increasing difficulty of preserving quality of care in our hospitals, in a time of budget cuts, reduced state resources, and declining admissions. We share information about the effects of depressed economies in rural areas, in the nation's breadbasket and its oil patch; about increasing numbers of uninsured and underinsured individuals that need care, resulting in greater uncompensated care and bad debts; about the high proportion of elderly that live in rural communities, resulting in a greater proportion of Medicare inpatient revenue; about aging plant and equipment and difficulties in acquiring capital funds; and about the effects of some small or remote rural hospital closures on access to health care services.

This hearing is an opportunity for dialogue on numerous issues facing rural hospitals today. The American Hospital Association pledges to work with you in seeking solutions to problems that inhibit rural hospitals in providing needed services to their communities.

Senator **Durenberger**. Kevin Fickenscher.

STATEMENT OF KEVIN FICKENSCHER, M.D., DIRECTOR, OFFICE OF RURAL HEALTH, UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE; AND PRESIDENT-ELECT, NATIONAL RURAL HEALTH CARE ASSOCIATION, GRAND FORKS, ND

Dr. **Fickenscher**. Thank you very much, Senator, for asking me to be here today. It is always a pleasure to come to this session as you are aware the last time I was here I had to catch the last flight home to North Dakota. I do not know what you did, but the flights leave later now, so, it is a lot easier to get home. I appreciate it.

I also, want to express my sincere appreciation to Senator Baucus and also to Senator Grassley for the legislation that they have introduced. I think that the bipartisan legislation that you have introduced will go a long way in the direction of solving some of the problems related to rural hospitals and maybe we can talk about that in the question and answer period.

I think it has been highlighted today very clearly, that rural America has some problems. When you look at the economic infrastructure of rural America, you look at forestry, you look at mining, you look at agriculture, you look at energy, it looks like an economic hit list. I think that has been a major problem and to look at health care and to see some of the dilemmas that we have been facing with rural hospitals is also important because hospitals are a major component of the economic infrastructure of rural America.

The changes that are made—that are being discussed, related to rural health and rural hospitals, I think are really quite important, because the Medicare system has a disproportionate impact on rural areas, since there is a larger percentage of elderly, who are using the services in rural America.

I have provided you with a written statement that outlines all of our various thoughts of the Rural Health Care Association, but I would like just a couple points in my oral statement.

I think we believe that it is very important that we eliminate the two-tiered system between urban and rural areas. The rural rate is—the base rate is less than 80 percent of the urban rate and that creates major problems, in fact in a lot of our rural areas we refer to things like the rural referral centers as honorary urbans, because it kind of has a perspective on the approach. It also, the two-tier system, when we are in procompetitive environment, represents anticompetition tax. It is important to replace that two-tiered system and to replace the urban-rural wage differential.

The second thing that we recognize that the capital issue is a real problem and quite frankly do not have a specific solution. I wish I did.

But, I think a fair way must be found to provide hospitals for compensation of their capital costs and we believe that it is going to be important to maintain access to the tax exempt financing. It is a real critical issue for rural hospitals, they have a difficult time competing in the capital financing market. And, access to that type of capital is important for them.

I am not exactly sure what should be done there, but I think we do need and I would agree with Ira Moscovice and his statement that we should hold off and really examine very closely that issue.

The points that are raised in your particular legislation, Senator Baucus, I think we are in favor of all of them. We feel that they very clearly would be of assistance to rural hospitals and I guess what we would suggest and this sort of get's to Senator Durenberger's question of providing capital resources for rural areas, is that we would also suggest that you consider establishing a grant authority for rural hospitals to help them make that transition.

It is very difficult to help them with diversification, with networking, with all the various approaches, without having some capital resources to accomplish that goal. Some major foundations in this country, specifically the W.K. Kellogg Foundation and the Robert Wood Johnson Foundation have made efforts along those lines. Those capital resources are not sufficient and we do need other kinds of efforts.

Final thing, I just want to—that relates to rural, does relate specifically to rural hospitals, is that as you are aware we had to work very hard to get a rural represenative on Pro PAC and the Office of Technology Assessment is setting up the Position Payment to Review Commission and I would hope that you encourage them to consider having a rural representative on that particular commission as well.

Thank you very much.

Senator Durenberger. Thank you.

[The prepared statement of Dr. Fickenscher follows:]

PROPOSALS TO ENHANCE THE VIABILITY OF RURAL HOSPITALS

Testimony on behalf of the
National Rural Health Care Association
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Presented by
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Before the Subcommittee on Health
Senate Finance Committee
Washington, D.C.
May 9, 1986

Mr. Chairman and members of the Subcommittee. My name is Kevin Fickenscher, M.D. I am President-Elect of the National Rural Health Care Association and Director of the Office of Rural Health at the University of North Dakota School of Medicine.

I would like to begin by thanking you for affording the National Rural Health Care Association an opportunity to testify before the Subcommittee on Health of the Senate Finance Committee. I would also like to extend our gratitude for your continuing appreciation and understanding of the issues which impact rural hospitals. Your attention to the issues we raised in previous testimony concerning a need for equity in payments for rural physicians' services and support of needed alterations in the overall reimbursement system to enhance rural health care services are most appreciated.

By way of background, the National Rural Health Care Association is a nonprofit membership organization composed of a diverse consituency of individuals and organizations sharing a concern for rural health. The Association includes administrators, physicians, educators, government workers and many other health professionals who serve in hospitals, community and migrant health centers, private practices, units of state and local government, and educational institutions. The primary mission of the National Rural Health Care Association is to improve the health of rural Americans by focusing attention and resources on improving the accessibility, quality, affordability, availability, and independence of health care in rural America.

The NRHCA is encouraged by the concern expressed by members of the Subcommittee on Health about the future of rural hospitals. We are aware of new legislation recently introduced by Senators Baucus and Grassley which moves in the direction of assuring the future viability of rural hospitals and the health care delivery systems of which they are an important part. We strongly support such efforts by the Subcommittee to address these concerns.

We are similarly encouraged by the recommendations of the Prospective Payment Assessment Commission (ProPAC) which urged the Secretary of Department of Health and Human Services (DHHS) to complete the congressionally mandated study of rural hospitals as soon as possible. Such a study is necessary and informed modifications to existing policy in an expeditious manner.

We clearly recognize the difficult task that the subcommittee and the members of Congress face over the next several months in gaining control of federal health care expenditures and other government costs. On the other hand, we also see serious problems on the horizon for the rural health care system that threaten the very existence of many rural hospitals and continued access to care for the many rural people that they are privileged to serve.

Rural hospitals are a critical element in the rural infrastructure. They are central both to the rural health care delivery system and to the local economies of the rural communities they serve. Rural hospitals are:

* among the largest capital resource investments of rural communities;

* usually among the top three employers in rural communities;

* the hub around which health care services may be organized;

* important in recruiting and retaining physicians and other health manpower; and

* an important provider of health services to the elderly and poor who lack transportation and resources to seek care elsewhere.

As we consider the effects of the Prospective Payment System (PPS) on rural hospitals, it is important to recognize the economic context in which many rural hospitals are operating. Rural economies are facing unparalled challenges in the 1980s. If we take the five major non-service industries in rural America -- farming, forestry, mining, petroleum, and light manufacturing -- it reads like an economic "hit list." Health care would head a similar list of services industries. Each of these sectors is declining, and each is exhibiting serious structural problems that are not likely to yield to overnight solutions.

What is a rural hospital? For many observers, the most critical factor is the number of acute care hospital beds. That may be an important measure, but it is only one of many characteristics of rural hospitals. Rural hospitals may more completely described as:

* small businesses subject to volatile swings in demand for and payment of the services they provide;

* institutions serving a high proportion of elderly and poor patients resulting in a greater dependence on payments from the Medicare and Medicaid programs;

* more susceptable to problems the policy changes in the Medicare and Medicaid programs due to the dependency issue;

* facilities with little or no capital cushion with which to absorb radical shifts in health care payment policy such as the Prospective Payment System;

* providing services to a smaller proportion of private paying patients to whom they can "shift" the cost of underpaid or unpaid for services;

* institutions that are more conservative and cost-conscious than their larger, urban counterparts; and,

* often operating in an overlapping labor and patient care market areas with a larger urban hospital in direct competition for both patients and staff.

Rural hospitals are similarly facing serious economic challenges brought about by the incredibly rapid changes in the health care environment during the past several years.

They are grappling with changes such as: the much discussed "corporatization of health care" which is transforming the "mom and pop" cottage health care industry into a series of corporate ventures; the continuing problem of attracting and retaining physicians in rural communities; and the dramatic decline in utilization of inpatient hospital services.

Most rural hospitals are generally supportive of the notion of paying prospectively for health services. It is at least a necessary improvement over the cost-based reimbursement system of the past. As you are aware, however, the implementation of the Prospective Payment System has caused some problems for rural hospitals. We believe it is clear that the Prospective Payment System is only one of several factors causing major problems for rural hospitals. What is not clear, however, is exactly how much of the trouble rural hospitals are now facing is attributable to the Prospective Payment System and how much to other factors. Because of these and many other technical factors, ProPAC was led to conclude: "Ultimately, however, the rural hospital policy debate may center on whether PPS, as currently structured, is appropriate for all rural hospitals." The National Rural Health Care Association would like to offer the following suggestions for your consideration as you grapple with ways to understand and solve the problems of rural hospitals.

I. Eliminate or substantially modify the current two-tiered system of payments under PPS.

Under PPS, rural hospitals are paid at a lower rate than urban hospitals. The "standardized amount" reflects historically lower costs in rural hospitals, and in FY1985 the rural rate was less than 80% of the urban rate. To these rates are added adjustments for cost differences such as area wage rates and teaching activity. These adjustments, when added to the standardized rate yield a payment to a rural hospital that is often 50% of the payment to an urban hospital for the same service in the same market area. This is simply unjust and should be changed in at least two fundamental ways: 1. The standardized amount should be a national or at least a regional rate. 2. The urban-rural wage differential should be replaced with a more refined gradient approach to adjusting for wage differences. These two measures would end the discriminatory underpayment to rural hospitals which penalizes them for historically achieving lower costs and ignores the marketplace realities in which they operate. These changes could be achieved without violating the integrity and positive aspects of the Prospective Payment System. In addition, these changes could be implemented without seriously affecting the federal budget since Medicare payments to rural hospitals represents only a small portion of total hospital expenditures -- especially when one excepts payments to rural referral hospitals. Therefore, the aggregate increase within the federal costs would be marginal.

II. A fair way must be found of compensating hospitals for their capital costs that does not disadvantage rural hospitals. Access to tax-exempt financing must be maintained.

The issue of how the Medicare program will pay for capital costs is an important and difficult problem for all hospitals. It is a particularly critical issue, however, for capital-poor rural facilities. Any problems resulting form federal policy on the issue of capital payment will have much more serious ramifications for rural hospitals due to their greater reliance on Medicare as a source of payment. The development of a workable DRG add-on for capital costs must take into account the existing legal commitments made by hospitals to repay principle and interest. At the same time, we recognize that any system of payment for capital costs should encourage hospitals to make cost-effective decisions about construction and equipment purchases in the future. A new policy should also avoid provisions that would have hospitals with low capital costs subsidize those with high capital costs. Until a more equitable method of treating capital costs is found, we recommend that the current capital pass-through method be continued for all rural hospitals.

Of particular importance to rural hospitals is the absolute necessity of retaining access to tax-exempt bonds as a method of obtaining capital. Many of the facilities built in the 1940s and 1950s under the Hill-Burton Program are in need of renovation or replacement. Tax-exempt bonds are in many cases the only affordable and available source of capital financing for rural hospitals.

Current proposals to cap the availabilty of tax exempt bonds within a geographic area would place rural hospitals at a marked competitive disadvantage with larger corporate entities. Similarly, it would be an error to allow tax-exempt financing only for new industry. In the current rural economy it is at least as important to retain existing industry (e.g., hospitals) as it is to stimulate new economic development. If rural hospitals are forced into the taxable capital market, they will find it difficult to compete with organizations which have more name recognition with investors, higher credit ratings, and more ability to absorb the additional cost of taxable capital.

III.New, broad-based solutions must be found to pay for the unsponsored care to replace rapidly disappearing "cost shifting" approaches.

Traditional methods of paying for public and private uncompensated care are now being quickly eroded by price-sensitive purchasers of health care services and insurance premiums. The impact of this erosion is greater in rural hospitals because they are: 1. more dependent on Medicare and Medicaid which usually pay less than cost for services to their recipients; 2. faced with increased numbers of low income, unemployed, and uninsured and underinsured people; and, 3. required to spread uncompensated care over a smaller proportion of private payors.

Timothy Size, Executive Director of the Rural Wisconsin Hospital Cooperative, presented a recent study as testimony before Senator Durenberger in April which illustrates the uncompensated care situation in Wisconsin. Wisconsin is probably not a typical state in that it has relatively good Medicaid payment rates and coverage, and it is not particularly poor or underserved. Some of the findings of Mr. Size's study were as follows:

* Rural per capita income is 89% of central city and 71% of urban fringe areas;
* Rural unemployment is 4% higher than central city[3] and 68% higher than urban fringe areas;
* The proportion of rural elderly below poverty is 78% higher than central city and 93% higher than urban fringe areas;
* Based on current rates approved by the Wisconsin Hospital Rate Setting Commission, Medicare is now paying rural hospitals about 90% of charges while paying urban hospitals 103% of charges;
* Medicare pays any hospital in Dane County (Madison area) about 50% more for the same work done by rural hospitals in the immediate surrounding counties;

* Unlike most urban hospitals, the majority of patients in the typical rural hospital are Medicare and Medicaid which results in a fewer number of private pay patients to absorb the underpayments of government programs. The combined effect of Medicare and Medicaid cost shifting results in rural hospitals with less that 50 beds using 28% of their private pay revenues to cover government underpayments, as compared to 7% for all hospitals;

* Rural hospitals with less than 50 beds subsidize Medicare (as a result of underpayments) at over five times the rate of the average hospital, and rural hospitals as a group have a subsidy rate almost three times the rate of urban hospitals;

* Rural hospitals with less than 50 beds subsidize Medicaid at a rate three times that of the average hospital, and rural hospital have a rate over twice that of urban hospitals;

* Hospitals located in the poorest quartile of counties (all rural) are dependent on government reimbursement programs for 60% of their revenues as compared to 45% in the most well-to-do quartile of counties, resulting in the poorest counties being most vulnerable to government program payment inequities;

* Hospitals with less than 100 beds (almost all rural) provide care to unsponsored patients at a rate 27% greater than the weighted average of all community hospitals;

- Hospitals located in the poorest quartile of counties provide nearly three times the proportionate amount of charity care as those hospitals serving the richest quartile;

- 35% of all rural hospitals had an operating deficit for 1984, as compared to 16% of urban hospitals.

It is clear from this study and other reports that rural hospitals are shouldering more than their share of the cost of uncompensated care, especially when it is related to their reduced ability to shift those costs to other payors. We must address these inequities or risk losing completely the access provided by rural providers.

IV. The Department of Health and Human Services should be required to review regulatory changes for their impact on rural providers.

At present, the DHHS is required to conduct regulatory flexibility analysis to identify any adverse impact that would accrue to small businesses or entities as a result of federal regulations. Unfortunately, DHHS has defined all hospitals as "small entities" which does not allow for discrimination between a 500 bed teaching hospital in Chicago and a 25 bed primary care hospital in rural Montana. There is obviously substantial room for differences in the way a regulation would impact institutions of this disparity.

We recommend that the Secretary of DHHS be required to review regulatory changes for their impact specifically on rural entities, defined as hospitals with less than 100 beds located outside a Standard Metropolitan Statistical Area. These institutions share several important characteristics, including that their demise would leave many people without access to services.

V. Appropriate thresholds for outlier payments should be established to provide more equitable outlier reimbursements for rural hospitals.

A ceiling for outlier payments to all hospitals has been set not to exceed 5-6% of total PPS payments to a hospital. Most larger, urban hospitals are approaching the outlier payment ceiling, but rural hospital are only at the 1% level. Further, it is projected that their outlier payments will only be about 2% of total PPS payments when the PPS system is fully implemented.

Rural hospitals are at a particular risk when the Medicare program pays significantly less than cost for a particular case. They have smaller operating margins to cushion the impact of such an expense; fewer private pay patients to whom they can shift the cost; and, smaller numbers of Medicare patients over whom they can average-out the extraordinary case. One small rural hospital in Idaho recently reported a case for which the total charges exceeded $30,000, but Medicare paid only about $1,500. The administrator noted that he had only projected an operating margin of $50,000 for the entire year. He clearly must take another look at his balance sheet subsequent to this case.

It is clear that this imbalance must be addressed. We are supportive of legislative provisions that would direct the Secretary of DHHS to set appropriate thresholds for outlier payments that will increase rural hospitals' payments to the level of other larger hospitals. We would recommend that this provision be extended to all rural hospitals with less than 100 beds located outside of Standard Metropolitan Statistical Areas (SMSA).

VI. The HCFA Office of Research and Demonstration (R&D) should be required to set aside 25% of their annual appropriation for projects addressing rural issues.

One of the problems frequently identified by ProPAC and others is the lack of good information about rural hospitals and health services delivery. Informed policy making is hampered without pertinent studies about rural problems and demonstrated solutions. You and we need to know what works and does not work in rural America. We can no longer assume that what works for large and urban will work for small and rural.

Research is often ignored, but it is very important. A small investment in research can yield substantial savings. It was research that gave us the Prospective Payment System which in its first year netted a savings of about $1.8 billion -- more than the combined, cummulative budgets of the National Center for Health Services Research and the HCFA Office of Research and Demonstration over the past 15 years. It is projected that PPS will save about $12.7 billion over the first five years of operation.

We recommend that the provision in the bill introduced by Senators Baucus and Grassley to set aside 10% of the HCFA Research and Demonstration budget be increased to 25% to better correlate with the percentage of Americans living in rural areas. We could, in fact, as easily justify a 33% set aside based on the proportion of the elderly population living in rural areas.

VII. An Office of Rural Health Policy should be established within the Health Care Financing Administration.

Some of the mistakes encountered in the implementation of the PPS could have been avoided if there was a central authority within HCFA to provide information and policy guidance. Clearly there are other areas within HCFA's jurisdiction that could benefit from addition expertise in the area of rural health (e.g., physician payments, rural health clinics, risk contracting, etc.).

We strongly support the provision within the bill introduced by Senators Baucus and Grassley that would create an Office of Rural Health Policy within the Health Care Financing Administration. In addition to its "watchdog" function with regard to health services reimbursement, such an office could assist HCFA in coordinating its financing policies with other agencies to assure that payment policies do not conflict with other federal policies, programs and initiatives that affect rural areas. This might include coordinating with programs within the Health Resources and Services Administration (e.g., Indian Health Service, Community and Migrant Health Centers, and Bureau of Health Professions).

VIII. Payments to rural hospitals should be made in a more timely manner.

Because they are small, very dependent on Medicare reimbursement and have few cash reserves, rural hospitals are particularly vulnerable to cash flow problems caused by delayed payments. We support efforts to require that rural hospitals' bills be paid within 30 days of receipt, or sooner if the intermediary pays other payees in less time.

IX. A new grant authority should be established to assist small, isolated rural hospitals in adapting to the changing health care environment.

Rural hospitals are faced with a critical need to adapt to a health care environment that is changing at a dizzying pace. There are alternatives among which rural hospitals can chose to improve their efficiency on the one hand, and to increase their ability to compete on the other. Some of these options are:

* reconsidering the mission of the hospital and its role in the community it serves;

* defining its services geographically and taking responsibility for developing a service mix to meet the health care needs of service area residents;

- reducing reliance on acute care services by downscaling and diversifying into other service areas;
- networking with other rural hospitals to find ways to share services and reduce costs;
- developing relationships with other, often larger, health care providers to improve the quality and scope of services; and
- linking with alternative health plans to develop new insurance products for their patients.

While not every rural hospital needs to act on all of these options, most should be at least considering them. It is ironic that the hospitals that most need to change are often the ones with the least human and financial resources with which to accomplish the task. We, therefore, propose that Congress develop a rural hospital assistance grant program that would help small, remote hospitals with the process of adaptation. Although we recognize that this proposal runs counter to the need to control federal spending, we believe that it will be less costly in the long run to have a small investment in assisting rural hospitals now than to wait until they close and try to resurrect them at a substantial additional cost to society.

In summary, the National Rural Health Care Association strongly supports the efforts of this subcommittee on behalf of rural hospitals. These facilities represent the cornerstone of the rural health care delivery system, and the stability of that foundation is being threatened. Rural hospitals are vulnerable to a variety of forces beyond their control but with which they must respond vigorously. You can help us help them by leveling the PPS playing field for rural hospitals. You can provide rural hospitals with an omsbudman within the federal bureaucracy that will understand their problems. You can provide them with resources which will help the weakest among them respond appropriately to the problems they now face.

Thank you again for the opportunity to share these thoughts and recommendations with the Subcommittee.

Senator **Durenberger**. Mr. Brim.

STATEMENT OF A.E. BRIM, PRESIDENT, BRIM & ASSOCIATES, INC., PORTLAND, OR

Mr. **Brim**. Mr. Chairman, Senator Baucus. This reminds me of a real lesson in civics in the tension between the executive and the legislative branch. I think we have a problem here. The prospective payment system was designed by Congress to put hospitals at financial risk. The purpose was both to reward efficiency and to penalize excessive costs. Unfortunately the regulations contained many provisions which do not take into account the unique circumstances of small and rural hospitals.

The point of fact in the State of Oregon in the last 90 days, two rural hospitals have closed; we manage nine hospitals in the State of Montana and six of these nine are in serious financial straits.

Our written testimony illustrates the problem of rural hospitals, which arise from current PPS practice. I would like to focus, however, on the extremely expensive and unfair nature of an appeals process in which the Government is the prosecutor, the judge, and then the jury.

Redbud Community Hospital is a 40-bed acute care sole community hospital provider located in Clear Lake, CA (northern California). The hospital serves a disproportionate share of Medicare and Medicaid, 80 percent at last count.

The issue here is whether HCFA should adjust Redbud's base cost year for the additional new services which came about because of the addition after the base year of intensive care unit and a pharmacy. The intensive care unit was recommended by the Joint Commission on Accreditation of Hospitals because of the extreme distance to that type of care.

HCFA took the position that the base year was not open for adjustment. If HCFA had prevailed, the reimbursement rate would have decreased and would not have included the cost of the pharmacy or the ICU until the completion of the first PPS cost report year and then the ultimate settlement of an appeal of PPS year cost report. The hospital was suddenly faced with a dilemma of having an inability to fund this bond fund reserve and to meet current obligations.

The Board and the community were forced to turn to the Federal courts and did receive injunctive relief on July 20, 1984, which prevented HCFA fron reducing it's then current payment rates. In its search of fairness, however, the hospital incurred legal fees, which averaging $20,000 per month.

Financially exhausted, and not having any progress with HHS negotiations the hospital settled for HCFAs offer on March 20 of this year. During the appeals process, Redbud incurred legal expenses in excess of $250,000. Lost reimbursements would have exceeded $500,000 over a three year period. In addition, I would remind the committee, that the costs of lost opportunity were great. We estimate that 30 percent of the time of the board and management and the consultants was spent dealing with a singular problem.

The Redbud case as a result of the injunctive action necessitated that HCFA provide a process for PPS rate adjustments for small community hospital providers. We reviewed this process, which they submitted and we feel that it provides no relief or equity for past distortions, that the proposed regulations would have have to go through annual repeat of the process and be a repetition of the Redbud experience, that is lengthy, complex, expensive and uncertain.

Based on our experience on Redbud and 50 other small and rural hospitals, we believe there is a definite need for an independent authority outside of HCFA, with a power to review HCFA decisions regarding exemptions and exceptions and empowered with the ability to override inequitable HCFA decisions.

We can only look to Congress for this relief.

Senator DURENBERGER. Thank you, Mr. Brim.

[The prepared statement of Mr. Brim and answers to questions from the committee follow:]

STATEMENT OF A.E. BRIM, PRESIDENT, BRIM & ASSOCIATES, INC.
BEFORE THE SUBCOMMITTEE ON HEALTH OF THE UNITED STATES
SENATE COMMITTEE ON FINANCE
RURAL HOSPITALS UNDER THE MEDICARE PROGRAM

MAY 9, 1986

INTRODUCTION

Mr. Chairman, I am A. E. Brim, President of Brim & Associates, Inc. We are a Portland, OR. based firm actively engaged in the management of small or rural healthcare facilities. Our firm is a wholly owned subsidiary of the Hillhaven Corporation, Inc. of Tacoma, WA. Hillhaven in turn is a wholly owned subsidiary of National Medical Enterprises, Inc., Los Angeles, CA. Our parent, the Hillhaven Corporation, is the second largest owner and operator of long term care facilities in the United States, with over 400 facilities in 43 states. National Medical Enterprises is one of the largest hospital management companies in the world. NME also is a network of some 20 interrelated subsidiaries that together form a total health care system.

We independently founded Brim & Associates in 1970 and since then have or currently are providing management services to more than 50 small hospitals and retirement centers, mostly in the intermountain and western states. Except for a few hospitals in which we are the lessor or share in the risk of the operation, the local community retains control of the institution through a local governing board. Some of our hospitals are not-for-profit 501(c)3 institutions, some are owned by public hospital districts, counties or religious organizations.

Prospective Payment System

To review briefly, Prospective Payment System (PPS) for Medicare inpatient hospital services was enacted by Congress as Title VI of the Social Security Amendments of 1983. The intent of PPS was to change hospital incentives through the introduction of financial risk. Under cost based reimbursement, hospitals had to spend a dollar to receive a share of that dollar in reimbursement. Under PPS, hospitals gained the opportunity to make a dollar by saving a dollar. PPS is based on a fixed price per diagnosis related group (DRG) paid for hospital services provided to Medicare inpatients. Initially, only hospital inpatient operating costs are covered by the payment rate.

The Small and Rural Hospital

Our managed hospitals, which we believe are typical, vary in size from 16 acute care beds (Jal, NM) to 115 beds (Missoula, MT). Most have under 50 beds. Many of these hospitals also have nursing home divisions, ranging from 22 to 111 intermediate care (ICF) or skilled nursing (SNF) beds. Most of these hospitals are located in communities under 10,000 population with some much smaller than that. We manage 10 hospitals in Montana, followed by fewer numbers in California, Oregon, Washington, Idaho, New Mexico, Colorado, Wyoming and Wisconsin. Recently we opened a Southeastern regional office in Greenville, NC and plan to manage small rural hospitals there in cooperation with Pitt County Memorial Hospital, Greenville.

Rural Hospitals form a vital part of their communities. Frequently the hospital is among the top two or three employers in the community, next to the public school system and a principal industry, such as a plywood, lumber or paper mill. Doctors living in the community care for patients there and typically the local hospital provides those doctors their only access to hospital or nursing home care for the community residents they care for. These hospitals generally provide primary and secondary care consisting of emergency rooms, general medical, surgical and obstetrical care, and as previously mentioned, often, long term nursing home care.

The nursing home residents mainly are aged infirm, retired members of the communities and of the farms and ranches in the vicinity who now require nursing home care. Most have family members living in the same small town or countryside and thus receive frequent visits and support from family members and friends. In one of our hospitals, one male resident is an aged, retired bachelor sheepherder. Accustomed to living by himself in isolated circumstances all of his life, he now requires extended nursing care and receives it from doctors, nurses and hospital employees, themselves members of the community, who are knowledgeable about his long time lifestyle and who thus are able to communicate with and support him in an accepted and meaningful way.

Problems Encountered by Small Rural Hospitals

Small rural hospitals confront an array of problems, some of which are peculiar to the individual institution but many that we see in almost all of our facilities. Some of these problems are only indirectly connected with PPS but they are so pervasive that we feel they merit enumeration:

- Low and fluctuating occupancy of acute care beds presents a constant problem. One of our facilities boasting 18 acute care beds has been operating this year with an average occupancy of one patient per day. While this is an extreme case, "no patient" days or days with only three or four patients are not an unusual occurrence in some of our hospitals. While nursing home beds usually are much better occupied, payment schemes for non-acute beds typically do not permit recovery of much more than direct costs, leaving little for application to fixed costs of the institution. The low order of acute care occupancy invariably leads to cash shortfalls.

- Cash flow problems present difficulties brought on by low occupancy, as recounted above, by reimbursement shortfalls, delays in reimbursement from third party payors, denied reimbursement, and unwillingness of hospital suppliers of goods and services to wait for payment of their bills. Suppliers inevitably put the errant hospital on a "C.O.D." basis and refuse shipment of goods until they receive payment in advance.

- Regulatory problems mark another small hospital area of concern. Later we will recount extreme financial and paperwork distress, including extensive legal fees, suffered by one of our hospitals as it sought relief from what it considered an unfair determination by HCFA. Although finally resolved, the problem required many months and thousands of dollars in legal fees and lost reimbursement to bring to closure.

- Diseconomies related to size surface another chronic problem. While large or urban hospitals have sufficient size to adjust for problems related to payment denials, DRG problems or bad debt experience, the small rural hospital has nowhere to turn. A single outlier Medicare patient may result in an overall operating loss for the month in which it is recorded. Later we will recount the serious problem encountered by one of our hospitals that recorded one outlier and recorded a substantial loss attributable to that very ill patient.

Primary Problems Encountered Under PPS

Those problems we have encountered under PPS include the following areas of concern. We should like to address each of them separately with examples taken from our own experience.

- Inequities experienced by the method and amount of payment for outlier patients

- Extreme financial penalties suffered by the rural hospital in mounting an appeal to the Prospective Payment System, even though such an appeal may be successful

- Penalties suffered by rural hospitals that experienced a decline in volume after their base year-end, and therefore are realizing low payment rates based on the PPS base year calculations.

- Future difficulties anticipated by rural hospitals as the proposed method for reimbursing for capital expenditures looms nearer

- The downward ratcheting of inpatient admissions due to increasingly stringent admissions criteria imposed by the Professional Review Organizations

- The threatened serious social and economic dislocations precipitated by the closure or impending closure of rural hospitals.

Inadequate Payment For Outliers

Losses in caring for day outliers and cost outliers have been well documented. In the rural setting, the absence of tertiary care capability and corresponding absence of subspecialty physicians tends to limit the application of expensive, stat the art technology. Thus, outlier problems in the rural community are more likely to be day outlier problems. While PPS provides for the outliers, our hospitals find that the threshold for day outlier payments vastly exceeds the approved DRG assigned day level, and so renders the outlier payment almost meaningless.

An elderly male patient was admitted to one of our hospitals with multiple problems and the primary diagnosis of Necrotizing fasciitis of the right ankle. Surgery was performed and subsequently a skin graft was required. Subsequent to this care, complications required an amputation of the lower leg. The patient later expired in the hospital.

The hospital charges totalled $39,573. Length of stay was 47 days. The DRG designated 14.3 days for the diagnosis. Reimbursement for the DRG totalled $4,258. The outlier reimbursement has not yet been determined, but the day outlier threshold for the DRG is 36 days. We estimate the outlier payment will add an additional $544.00 to hospital revenue, resulting in an estimated $34,771.00 loss to the facility for this patient. The loss on this single outlier places a significant financial burden on this rural hospital.

The Appeal Process

Rural Hospitals, because of their lack of resources, cannot mount lengthy appeals without sustaining severe economic loss. We have experienced this process at Redbud Community Hospital in Clearlake, California.

Redbud is a 40-bed acute care hospital in Northern California. It serves a disportionate share (80%) of Medicare and Medicaid patients. The issue involved was whether HCFA should adjust Redbud's base year costs for addition of new services added after the base year. Redbud added an Intensive Care Unit and opened a full service pharmacy after the base year. JCAH recommended that Redbud add the ICU because of the hospital's isolation from other hospitals.

HCFA maintained that the base year costs were not open to adjustment. Because Redbud has such a large percentage of Federal program patients, its ability to pass on its higher operating cost was severely restricted by HCFA's refusal to adjust the base year used in determining the PPS payments.

Had HCFA been permitted to decrease Redbud's interim payments to reflect the disallowance of the increased ICU costs and Pharmacy costs, the hospital would not have been able to fund its bond reserve accounts and therefore in technical default on its bond covenants. The hospital also likely would have been unable to pay its bills and therefore have become insolvent. However, on July 20, 1984 the hospital obtained an injunction in Federal court to prevent HCFA from reducing its reimbursement from its then present level. If Redbud had followed program regulations, its reimbursement rate would have been immediately decreased and could not include costs for the ICU or Pharmacy until completion of the first year under PPS and ultimate settlement of the appeal of its PPS year cost report. That condition could have lasted well into 1988 or 1989 depending upon the backlog of Provider Reimbursement Review Board (PRRB) caseloads.

Note, however, in the above discussion, there was no requirement in the injunction to increase the payment rate for Redbud from the level in July, 1984. During the same period Redbud experienced an increase of its case mix index which indicated a higher percentage of severely ill patients entering the hospital. The additional care required caused the hospital to incur more expenses to treat the more acutely ill patient loads. However, under the injunction the payments could not be increased. Redbud was forced to lay off personnel and curtail capital expenditures to prevent serious losses. During this two year period Redbud was paying legal fees of approximately $20,000 per month to continue its battle against HCFA. HCFA obviously could continue the "negotiations" indefinitely. Redbud recently settled this issue with HCFA as the hospital could not continue any longer and settled for HCFA's offer. The legal bill was approximately $250,000.

In the cost report for 1984 the hospital lost $210,000 in reimbursement due to exclusion of the ICU and Pharmacy. The hospital requested an adjustment of its TEFRA target rate which is allowed for in the TEFRA regulations and HCFA allowed only $87,000 explaining that the remainder of costs were "unreasonable". In 1985 the hospital was required to file a TEFRA type cost report since it was prevented from going onto PPS by the injunction. The hospital lost an additional $206,000 in reimbursement on that report. For the current year to date the hospital has been under reimbursed about the same rate as the prior year, or $175,000.

To settle the case with HCFA has taken two years, $250,000 in legal fees and $504,000 in lost reimbursement.

Table 1, page A shows a breakdown of legal costs and lost reimbursement.

Penalties Suffered by Rural Hospitals That Experienced Volume Declines After the Base Year

Clark Fork Valley Hospital, Plains, MT serves as an example of how PPS can adversely affect hospitals with fluctuating volumes. While the problem does not relate exclusively to small hospitals, still the small financial base of Clark Fork gave rise to this severe financial difficulty.

Because PPS relies on a base year for the hospital specific component, a hospital that experiences a sharp decrease in volume after the base year is severely penalized. The Medicare cost per discharge during Clark Fork's base year was $1,359.62. The hospital experienced a large decrease in census after the base year of September, 1982 and the Medicare cost per discharge in FYE September, 1983, increased to $1,935.31. This increase in cost resulted in a loss of reimbursement of $127,274 in the TEFRA year. In the first year of PPS, because of the blending of Federal portion with the hospital specific rate, the hospital's loss decreased to $49,740.

Clark Fork Valley Hospital continues to receive its low reimbursement rate. Not only is the hospital specific component too low, but the wage index for rural Montana continues to depress payment rates in rural Montana.

Clark Fork Valley was a sole community hospital (SCH). PPS allows the SCH to "give up" its status as a SCH in order to take advantage of the higher DRG rate by sliding on to the Federal portion and not maintaining the 75% hospital specific ratio for the three years under PPS. Accordingly, Clark Fork Valley gave up its status in order to take advantage of the much needed higher rate. However, in so doing, the hospital also forfeited its right to adjustments for SCHs. This is because sole community hospitals that experience a drop in census of five percent or more from their preceeding year can apply for an exception to help cover fixed costs that otherwise would not be reimbursed. But the decision to drop SCH status is irreversible, so Clark Fork Valley never will be able to achieve protection from drops in volume even though the hospital continues to function in fact as a sole community hospital.

CAPITAL PAYMENT ISSUES

The department of HHS has proposed to reimburse hospitals for capital on the basis of prospective rates beginning in 1987. The rates would be based upon cost reports for FYE 1983. There would be a phase in period of four years. HHS is also proposing separate rates for urban and rural hospitals. The rural rate would be only 59% of the urban rate. Sole community hospitals would be reimbursed on the formula of 75% hospital specific (based upon 1986 cost data) and 25% national rate. Return on Equity would be phased out in three years.

From a rural hospital's point of view, the proposed capital payment plan continues the discrimination against rural facilities. Administration assumes that ALL rural hospitals should be penalized for their location. Rural hospitals need to upgrade physical plants and equipment just as urban hospitals do. Costs of construction and equipment is no less than for urban areas. Yet rural hospitals are to be paid less than urban hospitals for capital costs.

Another critical issue regards sole community hospitals. Although SCH's continue to receive 75% of their payment based upon their capital expenses in 1986, still 25% is based upon a national rural rate. As pointed out above, separating rural and urban capital payments is discriminatory and unfair. Picking a base year and rolling that amount forward will prevent many rural facilities from replacing aging physical plants or equipment if those hospitals' current payment for capital reflects old and aged plant and equipment. This problem is an enormous hurdle for rural facilities with high Medicare and Welfare populations.

It should also be pointed out that many sole community hospitals gave up their sole community provider status during the second year of PPS in order to obtain the higher National PPS rates if their base period costs were low as pointed out in the Clark Fork Valley Hospital situation. Regulations currently state that the decision is irrevocable for those sole community hospitals which gave up their status. Therefore those hospitals, which are still actually sole community providers, will be denied the protection available in this proposal.

Two examples outline how the above issues are a serious threat to rural hospitals.

Divine Savior Hospital is a religiously affiliated hospital in Portage, Wisconsin. Divine Savior has 73 hospital beds, and 111 nursing home beds. It is the major employer in the area. Because there is another small hospital 16 miles away, Divine Savior is not eligible for sole community provider status. The hospital completed a major remodeling project a few years ago. The existing structure was very old and required extensive remodeling to make it acceptable for delivery of health care. If the HHS proposal is implemented, Divine Savior will lose $408,000 during the four year phase in, and $221,000 per year thereafter assuming no additional capital investment. This amounts to $87 per discharge or about 50% of the proposed payment amount for rural hospitals. With Medicare and Medicaid running at 63% of total patient days, it would be impossible to recoup this amount from other payors, particularly since Wisconsin has rate review laws controlling price increases for hospitals.

Northeastern Regional Hospital is a community owned nonprofit hospital in Las Vegas, New Mexico. It is located 45 miles North of Santa Fe. The nearest neighboring hospital is in Santa Fe. Northeastern Regional is a sole community hospital. The hospital has 62 acute care beds in service. Medicare and Medicaid patients constitute 64% of its inpatient volume. The hospital construction was financed with revenue bonds. Its actual capital cost per discharge is $560. Because it has sole community provider status, the negative impact of the HHS proposal would be $337,400 for the four year phase in, and $93,000 per year thereafter. If the hospital had elected to forfeit its sole community hospital status, it would have lost $711,000 during the phase in and $373,000 each year thereafter, thereby incurring even greater penalties.

In summary, we feel that rural hospitals clearly are discriminated against in this proposed capital payment plan. It will prevent rural hospitals from replacing aging assets, and will force many into closure. The plan will inevitably limit access to care for the elderly and other citizens in the rural areas. Secondly, the many sole community hospitals that elected to give up SCH status during the early part of PPS implementation, will experience additional burdens under the proposed HHS capital regulations.

Downward Ratcheting of Admissions

The rural hospitals we work with are encountering increasingly stringent admissions requirements by the Professional Review Organizations. In this statement, we refer to this phenomenon as "downward ratcheting".

Admissions are denied because they are judged inappropriate based on the allegation that the treatment could have been delivered on an outpatient basis given the absence of complications. Other denials are for patients admitted in the last stages of life who enter the hospital and expire in a day or two. These are deemed by the PRO to be admissions of a social nature.

These difficulties are best explained by examples.

A 76 year old male patient suffering from chronic obstructive pulmonary disease (COPD) and aplastic anemia, who also had an obstruction of a femoral artery and a carotid artery came to the hospital for an infusion of two units of blood. Because of the doctor's concern over the patient's compromised pulmonary and vascular status and the complications that might arise from the infusion of the blood, the doctor admitted the patient over night. The admission was denied.

Another male patient in his seventies came to the same hospital for a hernia repair, ordinarily only eligible for outpatient treatment under Medicare. This man had suffered a myocardial infarction a few months previously. In addition, he lived in a remote rural area 36 miles from the hospital. Because of concern for the man arriving home safely and possible post-surgical complications, the doctor elected to keep him in the hospital overnight. This admission was denied.

Our hospitals occasionally admit patients in the final stages of life. These patients typically are suffering from cancer and the family members are unable to give intensive care in the final period and are phychologically unprepared for dealing with the impending in-home death. These admissions routinely are denied because they are asserted to be of social rather than of medical necessity.

Rural hospitals frequently operate in areas remote from patients' homes and from other medical and social care agencies. In the cases of the two aged male patients, no other agency existed to watch over them in event they did not progress well. In the city, good transportation systems, adequate ambulance service and nearby hospitals could fulfill this need. In the case of the dying persons, a hospice service in the city might support the patient and equip family members to deal with the impending death. The rural community usually has no comparable service. The isolation of the rural hospital should be considered by the PROs and by Medicare in judging the validity of these admissions.

Threatened Social and Economic Dislocations Caused by Closure or Impending Loss of Rural Hospitals

Possible inability of hospital governing bodies to meet total economic needs of their institutions could only partially be attributable to PPS. Nonetheless, I would like to point out some perceived and real consequences of failure of the local hospital to survive.

Despite the problems of operating healthcare establishments in rural communities, residents in those towns do everything possible to maintain their healthcare structure. It is commonly understood by business people that when the citizen leaves town to obtain medical care, he takes his healthcare dollar with him, spending it elsewhere. In addition to the doctor visit or the hospital stay in a distant town or city, the local resident tends to spend other dollars there as well. Grocery shopping, furniture and clothing needs, for example, are attended to during the healthcare trip and the local economy suffers as a result. When an entire hospital is threatened with closure, the consequences loom as a major local disaster, comparable to the closure of a principal industry in the town. In such an event, the job loss seriously impacts the economy of the region. In like manner, the social fabric of the community is impacted. Local institutions, such as the school system or a lumber mill, generally believe they will experience difficulty in attracting qualified job applicants to a community that has no organized healthcare system. In the absence of a hospital, the mill loses an industrial medicine resource and an emergency treatment resource when industrial accidents occur.

Care of the aged ill and infirm constitute a primary concern in a community when the loss of a combination hospital and nursing home is threatened. In many rural communities, the aged have lived out their lives in the small town or on a nearby farm or ranch and have nowhere to turn locally if no facility exists to care for them. In such cases, adult children are forced to transport their parent to a distant town or city for the needed care. In one case, a son took his aged father to his own home city, 400 miles away, because there was no place for the father in his own community and the son would not leave him in the long term care of strangers elsewhere, with no family or friends to visit and give support. The list of similar anecdotes is endless.

Within our own experience, we are presently closing a small hospital on the southern Oregon coast located at Toledo, OR. This community has a population of about 3500 and a hospital catchment population of about 6000. A hospital was built in Toledo about 25 years ago. A depressed economy on the southern Oregon coast, coupled with long term operational difficulties, left this institution in a debt ridden state that the board of directors felt powerless to overcome. The hospital closed earlier this year.

This hospital employed 80 workers, full and part time. The Administrator estimates about 60 full time equivalent employees worked here. The hospital was the third largest employer in Toledo, next to a paper mill and a lumber mill. The annual payroll totalled about $1,200,000. This payroll loss followed the closure of a plywood mill about a year and a half ago when about 300 jobs were lost.

At closure the hospital provided the only obstetrical care in a region extending 50 miles to the East, and over 30 miles to the North and South. A nearby rural facility undertook obstetrical care on an improvised basis, and currently seeks State approval for an obstetrical program, so that capability will not be lost to the area.

A year prior to the hospital closure, six doctors practiced in Toledo. Presently, only one doctor remains to care for the 2500 residents and the balance of the 6,000 in the catchment area.

The hospital building is for sale, presenting a challenge to the sellers. A special purpose building, such as a hospital, is not readily useful for other purposes, despite its good condition.

There are other rural hospitals in small towns relatively near by, so this case speaks to access only for the aged and poor without transportation. The case is intended to point out economic and social dislocations experienced whenever a rural community loses its hospital.

Special Provisions of the Medicare Program Applicable to Rural Hospitals

We feel that the Swing Bed provision generally is a valuable asset to small rural hospitals. However, at least one jurisdiction, Oregon, does not yet have any approved swing beds. Reasons supporting swing beds include additional revenue producing capability provided swing bed providers, a needed resource for patients who no longer qualify for hospital stays but who meet criteria for admission under the swing bed guidelines, and a community resource when other similar capabilities do not exist in the community. On the negative side, some nursing home associations are adamant in their opposition to the approval of swing beds in hospitals, on the basis that adequate numbers of skilled beds already exist in the communities. Additionally, a few governing bodies and administrators may hesitate to institute swing bed programs if they feel the institution will become primarily an ICF or SNF facility. Possibly a new designation for swing beds, for example "sub-acute beds", would be useful.

We believe that those hospitals that have received the sole community hospital designation have benefited from the provisions. However, the SCH status is not beneficial to those hospitals that incurred low base year costs. Low base year costs could be caused by unusually high volumes in the base year. In addition, those hospitals with attached nursing homes may also have unusually low base year costs because the Medicare cost allocation process over allocates overhead to the nursing home and therefore dilutes the hospital's costs. In those cases, those institutions have not been afforded the opportunity to take advantage of the SCH status. Earlier, we commented on the loss of SCH designation experienced by some hospitals when, early on, it was advantageous for them to give up their SCH designation. In those cases, we commented on the penalty they will incur by that action because they will be prohibited from regaining the SCH designation.

TABLE 1

Legal costs and lost reimbursement realized by Redbud in its long litigation against HCFA:

Legal Costs	$ 250,000
Lost reimbursement	
1984 Cost report	123,000
1985 TEFRA report	206,000
1986 Cost report (est)	175,000
Total costs & last reimbursement	$ 754,000

Conclusion and Recommendations

PPS has demonstrated an innovative and largely successful interval in the evolution of this country's healthcare delivery system.

PPS was designed for a system of averages. The individual rural healthcare establishment runs afoul of averages, however, because usually it is so small it cannot accommodate to sizeable swings in occupancy, length of stay or cost fluctuations.

As this page is written, a second Oregon hospital has just announced its closure, scheduled for May 1. Located in Pendleton, OR., a community of about 12,000. Pendleton Community Hospital has until recently furnished the only obstetrical and gynecological service in the community, in addition to other traditional services. When it closes, the other Pendleton hospital, St. Anthony's, will care for area residents. But 90 jobs will be lost and the alternative choice provider will cease to exist. The published reasons for closure include decreased Medicare reimbursement, but apparently this is not a major reason.

PPS can help rural hospitals to survive or it can hasten their demise. It can help by recognizing the unique nature of the rural hospital in its community.

Specific relief can be afforded in the areas discussed in this statement.

- Outlier payments: An approach to thresholds should be adopted that decreases the number of days between the DRG approved and the threshold day in order not to penalize the hospital for caring for very ill patients.

- Base year problems: The present system of using 75% hospital specific rates for the SCH should be continued, but modified to include adjustments for changes in services subsequent to the base year.

- Capital reimbursement: The present system of cost reimbursement for capital costs for sole community hospitals and rural hospitals under 100 beds should be continued. Opportunity should be provided to reinstate the rural hospital to SCH status for purposes of capital pass through.

- Ratcheting Admissions: PPS should advance a more lenient approach to admissions that recognizes the unique medical and social services provided by the rural hospital in the absence of other such providers in the community.

- Importance of survival: PPS should demonstrate an attitude that will encourage the survival of the rural hospital rather than design the demise of a substantial number of rural community providers. One step toward accomplishing this objective is to eliminate the discrimination against rural hospitals by modifying the national and regional rates to be the same for urban and rural facilities.

- Appeal process: Streamlining of the procedures should be set in place to afford a more timely and less expensive method of arriving at a conclusion to the dispute.

- Impartial review: The Congress should consider legislation to establish an independent authority outside HCFA with the power to review and when indicated preempt HCFA decisions on exemption and exception requests.

Brim & Associates, Inc.

May 22, 1986

United States Senate
Committee on Finance
Washington, D.C. 20510

ATTN: Shannon Salmon

Ladies and Gentlemen:

Accompanying this letter is a written response to follow-up questions from Senator Packwood regarding testimony of A. E. Brim to the Subcommittee on Health on May 9, 1986.

If you would like technical expansion, we would be pleased to respond in detail to any of these premises. We are appreciative of the opportunity to testify and trust that Congress will exercise its legislative prerogative to enhance and improve rural health care in America.

Sincerely,

A. E. Brim
President

AEB/ch

Enclosure

cc: Edmund J. Mihalski

CORPORATE OFFICE 177 N.E. 102nd Avenue Portland, Oregon 97220-4199 (503) 256-2070

Follow-up Questions from Senator Packwood

for Mr. A. E. Brim

1. **In the hospitals managed by Brim and Associates, what techniques are employed to attract area residents, rather than have them travel to services offered by larger, urban hospitals?**

The phenomenon of area residents leaving one community for another to seek health care is referred to as "outmigration." This exists among all providers and is not unique to rural hospitals. The renaissance of the rural hospital's efforts in protecting and increasing its market share is substantially assisted by recruiting and, if necessary, employing quality physicians in rural communities. The citizens of these communities must have confidence in local physicians if the rural hospital is to be a true provider of acute care; therefore, conscientious recruitment by communities of qualified physicians, and, if necessary, the provision of economic and noneconomic incentives is an important technique.

Technology is a factor in attracting rural residents. It is important that the smaller hospital provide competitive but appropriate technology. An example would be whereas a CAT scanner in most instance is inappropriate, the presence of ultrasound diagnostic equipment is a necessary level of technology for a rural facility. Hospitals must have the revenues and available capital to offer these services.

Lastly, countermarketing is an important technique. Several years ago, large urban hospitals began "raiding" rural communities as the urban hospital itself became more concerned with falling patterns of utilization. It is now necessary that rural communities, through the leadership of boards of trustees of rural hospitals, make known the unique advantages and services of the rural hospital.

What new techniques are your hospitals using to solve their financial plight?

Let me begin by stating that the opportunity of cost reduction has been pretty much exhausted in all hospitals. Costs over the past six years, through the impact of TEFRA and then through the introduction of Prospective Payment, have brought operating costs down to the absolute minimum tolerable level considering the necessity of providing standby services in the rural community. The smaller hospital has naturally smaller nursing units and, consequently, minimum staffing requirements for these units is an example of the inability to further reduce costs.

There are two solutions to solving the hospital's financial plight which go beyond the simplistic advocacy of urging rural hospitals to join other systems. It is necessary to recognize that the moment a rural hospital joins a system, it becomes a tributary, in most instances, of large urban hospitals and, as such, community control is frequently lost.

Our hospitals impove their economic status by providing broad-based community services within the rural primary and secondary service areas. An example is the installation of a number of hospital-based home health services. Another example is the provision of more and more outpatient services to the community and to the local physicians, thereby lessening dependency upon inpatient services. Of course, every rural hospital whose circumstances warrant it should employ the swing bed concept for financial improvement.

The second technique which rural hospitals are using to solve their financial plight is an appeal to the federal government to stop cost shifting. As Medicare and Medicaid pay less and less of the true cost of the hospital operation, more of these costs are thrown over to the private patient or the patient with private insurance. In the rural community with limited incomes, these people simply cannot afford these costs shifts, and we very much advocate enhanced payment to hospitals from federal programs to stem the economic exsanguination caused by this phenomenon.

2. Your testimony discusses the financial penalties suffered by rural hospitals that mount an appeal to the prospective payment system. What recommendations would you make to improve or adjust the appeals process?

The appeals process can and should be improved by the following:

1. Establish absolute and fairly short time limits of response in appeals. Mandating timely resolution to alleviate the unfair match of a government with seemingly inexhaustable, bureauracratic personnel facing a rural hospital with very limited resources for legal and administrative response.

2. Establish an independent board outside of the department of HHS or HCFA so that fairness is the outcome of the appeal--fairness to the government and fairness to the community hospital.

3. We would like to see a more liberal definition of "community medical need," on which adjustments would be based. Our experience tells us that this concept is very narrowly defined in present practice and that quality health care to the rural community demands that "community medical need" be more focused on providing a broad range of services within the rural community as opposed to the "transportation syndrome" which presumes that people can be moving willy-nilly to large urban centers for care.

Senator DURENBERGER. Curtis Erickson.

STATEMENT OF CURTIS C. ERICKSON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GREAT PLAINS HEALTH ALLIANCE, PHILLIPSBURG, KS

Mr. ERICKSON. Mr. Chairman, Senator Baucus. I appreciate the opportunity to appear, with this panel and before this subcommittee. My name is Curtis Erickson. I am president and chief executive officer of the Great Plains Health Alliance in Phillipsburg, KS. We operate 25 hospitals in Kansas, one in Nebraska, all with less than 50 beds. We have been operating rural hospitals as a multisystem since 1951. It might be interesting to the subcommittee that out of the 26 institutions, 25 of them are owned by counties, districts, and cities.

I have submitted a written statement, but I want to comment on just a few points and I will hopefully not comment on the same things that have already been covered by others.

I would emphasize a few points about the rural hospitals greater risk of recovering costs under PPS. One of these that of course has been mentioned is the expensive atypical case. The rural hospitals small number of cases does not permit the law of averages to function to recover their costs.

I give a specific example in my written statement, about one case in a hospital in Kansas, which consists of 2.4 percent of the operating costs of that institution. That is going to be difficult for them to recover and I will mention later on that most of these hospitals are recovering that cost by local taxes.

Having spent thirty years in the industry of operating small rural hospitals, I am concerned about the access to quality care in the rural areas. I think we are certainly close to losing these hospitals developed through the Hill-Burton program. It seems to me that we need to be very careful that the whole rural primary care system used by the recipients of Medicare does not become jeopardized by the fact that we lose these institutions.The way many of the hospitals in Kansas make up their operational losses is with property taxes.

One concern on the rural referral center problem which and I think Senator Dole mentioned involves a specific situation in Kansas. This referral hospital is very important to the northwestern section of Kansas but does not have 6,000 dismissals. Under the Reconciliation Act of 1985, (Cobra) the Osteopathic hospitals were allowed a designation as a rural referral center with only 3,000 dismissals. I hope that may be made the required dismissals for other referral centers.

I have one comment in regard to the swing bed program. It is very effective and all of our hospitals have it. It is an excellent program but we believe that some things need correction and in my written testimony I comment on these items.

In conclusion, I want to reemphasize, that without the small rural hospital, most Kansas rural communities would have a more severe shortage of physicians and other manpower than they now have. I believe that we certainly must figure out a method of assisting those hospitals and the necessary rural areas to keep in business and not be involved in a crisis situation, which would bring forth some emergency legislation.

I just want to comment on one other question that has been asked. I think maybe that some of the transition capital that Senator Durenberger mentioned might be used to sustain primary health services in the rural communities. Thank you.

Senator **Durenberger**. Thank you.

[The prepared statement of Mr. Erickson follows:]

Senate Finance Committee
Subcommittee on Health
to Examine Rural Hospitals
Under the Medicare Programs

9:30 a.m., Friday, May 9, 1986
Room S-D 215 Dirkson Senate Office Building

My name is Curtis C. Erickson. I am President and Chief Executive Officer of Great Plains Health Alliance, Phillipsburg, Kansas, an organization which operates under contract management and lease 25 hospitals in Kansas and 1 in Nebraska each with less than 50 acute beds. For this discussion regarding rural hospitals under the Medicare program, I would like to divide it into three sections:

I. The Impact of the Prospective Payment System on the stability of small, rural hospitals

II. Concerns about maintaining access to quality care in rural communities

III. Effect of other program elements, i.e.:
   1) rural referral center provisions
   2) swing-beds

I. The Impact of the Prospective Payment System on the stability of small, rural hospitals.

The small, rural hospital is at a greater risk of not recovering their costs under the Medicare Prospective Payment System (PPS) for two major reasons. First of all, PPS is a system based on averages. In many rural hospitals, the small number of patients served does not permit the law of averages to function. Therefore, one expensive or atypical case can place an unrecoverable financial burden on the small, rural hospital.

Examples which I have included are, one of our rural Kansas hospitals which, in its 1985 fiscal year, had a loss from operations of $42,564. In the current fiscal year, this hospital has already served five Medicare beneficiaries whose unreimbursed charges totaled more than $42,000. This is a significant portion of that hospital's revenue, but more importantly, is 2.4 percent of the hospital's operational costs. As a result, this loss will have to be subsidized with local ad valorem taxation on property in that county.

Another case reported to us just recently is for a Medicare patient currently in the hospital. This case has unrecovered costs of more than $15,000. A fellow administrator from Idaho shared with me a case where the contractual adjustment on one patient in his hospital amounted to $31,429. In addition, his hospital has had a total of nine cases with a contractual adjustment of more than $70,000. These are just three examples -- there are many more. But these cases demonstrate the problem rural hospitals face with outlier cases. Even though we may average out on other cases much better, it would take hundreds of cases to even begin to offset the losses which are incurred on these extreme outlier cases.

The second reason small, rural hospitals are at a greater financial risk under PPS is related to size. The size of small rural hospitals severely limits both the benefits from economies of scale and the ability to make further cost reductions. Fixed costs for these hospitals -- which in most cases includes personnel costs -- represent a large proportion of the hospital's overall costs per case. From the experience in our organization, we also believe many rural hospitals in our area have been conservative in nature and have already decreased costs by personnel reductions. In many cases, these reductions were made during or prior to the 1982 base year for PPS.

Data from small, rural Kansas hospitals of less than 100 beds demonstrates the severity of the decrease in acute care patients. The Kansas Hospital Association's (KHA's) Patient Origin and Utilization Study, which includes all community hospitals in Kansas, shows from 1981-1984 acute care discharges for Kansas hospitals of less than 100 beds have decreased 25 percent. According to the 1985 KHA Fiscal Trends Survey, discharges decreased another 12 percent from 1981 levels representing a total decrease of 37 percent over the five year period (1981-1985).

This group of hospitals (under 100 beds) represents 112 hospitals or 77.1 percent of Kansas' community hospitals. The rurality of the state, in particular the Western half (40,000 square miles) with a population density of 10 people per square mile, would indicate the presence of a large number of small providers.

For comparative purposes, Kansas hospitals over 100 beds showed a 21 percent decrease in discharges from 1981 - 1984 on the KHA Patient Origin and Utilization Study and a 25 percent decline from 1981-1985 based on KHA'S Fiscal Trends Survey. This demonstrates small, rural Kansas hospitals (under 100 beds) have been more drastically affected by declines in inpatient utilization than larger rural or urban hospitals. A significant problem that must be addressed in PPS is the lack of financial flexibility small hospitals have because of their high percent of fixed costs. This makes it impossible to significantly down size operations in order to accommodate the corresponding decreases in inpatient utilization. This inflexibility will not allow the small hospital to cover their costs per case with the current PPS rates. In rural Kansas, it is imperative to maintain small hospitals if access to quality primary care is to be preserved. Presently the only thing covering this shortfall in Medicare's payment is local property tax support. In light of the current economic problems associated with rural Kansas and rural America, dependence on this support is certainly at risk.

Since Medicare beneficiaries represent greater than 50 percent of these rural hospitals' patients, these hospitals' financial viability is largely dependent on the PPS payment. In reality, a 29-bed hospital in Phillipsburg, Kansas has very little control over more than 55 percent of its budget because the price is fixed in Washington. Furthermore, the hospital cannot further reduce their operations to survive within this price and continue to meet the requirements of the Medicare program and the needs of Medicare patients.

As a possible solution to this dilemma, we would suggest Congress consider re-basing the PPS rates with more current hospital-specific cost and discharge data to more adequately reflect the payment needed to support continued access to primary health care in rural communities.

Another reality associated with reduced utilization in the small hospital is that the less costly personnel positions are eliminated first, i.e., an aide position is terminated before a registered nurse. This could have an effect on the hospital's wage index as it compares to the PPS wage index.

It has also been well established the acute care patients served by hospitals now require a much higher intensity of services. Yet hospitals must try to meet these higher patient care needs with a much smaller number of staff.

I also want to mention the problems rural communities face as a result of the recent changes in Medicare's clinical lab fee payments. These changes tie Medicare's payment for hospital outpatient lab services to the payment for similar services in independent labs. This has caused rural hospitals a serious loss of revenue. A survey of 23 of our organization's hospitals discovered the hospitals' losses for Medicare laboratory services amounted to more than $200,000.

In rural communities, our hospitals' costs for outpatient lab services are higher than independent labs. This is due primarily to the low number of cases treated. It is a two-fold problem. First, rural hospitals do not have immediate access to the services of independent labs. Second, even if independent lab services were readily available, we would still have to maintain some lab support in the hospital. Thus our lab costs would not go down. Most of our costs are fixed -- personnel costs especially, you cannot reduce below one.

I must also note that under PPS, regulation has increased, not decreased. Medicare cost reporting, billing requirements and utilization review requirements have all been increased. This obviously increases the hospitals' administrative burden and costs.

II. Concerns about maintaining access to quality care in rural communities.

Since World War II, through the Hill-Burton Act, we have made significant and successful efforts to provide access to health care in rural communities. Through the health planning acts of recent years, we continued to pursue this goal. At the present time reasonable access to quality care continues to exist in our rural communities.

However, should a 1987 Medicare budget proposal that reduces or even freezes PPS payments be enacted, then many of our small rural hospitals -- because of their large percentage of fixed costs -- may not have the ability to maintain the resources needed to provide primary health care services in their rural communities.

Another access issue that needs to be addressed in recognition of declining acute care utilization, is for rural communities to rethink the total primary care process. In order to do this, communities will need to assess in what form quality primary health services can be delivered. In some situations, we believe patient volumes may dictate the need to totally restructure the primary health services of these rural communities. We would certainly be very receptive to funding for grants and demonstration projects to address primary care alternatives for our rural communities.

The incentives of PPS are to provide care in the most cost-effective settings. Yet Medicare -- through many regulations, criteria, approvals, etc. -- makes it very difficult for patients to qualify for these cost effective services including skilled nursing care and home health care. Many of the patients served are from single person households which even further establishes the need for such services.

III. Effect of other program elements.

1) Rural Referral Center Provisions

There is a rural referral center in western Kansas which, because of current Medicare PPS criteria, cannot be designated as a rural referral center. The hospital is Hadley Regional Medical Center, Hays, Kansas. A discussion of this hospital's situation is an appropriate example of the problem with the rural referral center criteria. Hadley Regional Medical Center serves as a secondary care rural referral center for northwest Kansas. Its service area encompasses the twenty counties of northwest Kansas, or almost one-fourth of the entire state. Patients needing the highly specialized medical staff and hospital services available in Hays would have to travel 100 miles east to Salina, 180 miles southwest to Wichita or 300 miles west to Denver to receive similar specialized services if the services were not available in Hays. Furthermore, Hadley is a major provider of services to Medicare beneficiaries. Fifty-one percent of Hadley's inpatient days are for Medicare patients.

When the Medicare program recognized the need for increased DRG payments for rural referral centers, there was no provision for such a highly unique hospital such as Hadley Regional Medical Center. Because of its small size of 125 beds and service area which is so rural and sparsely populated, Hadley has been unable to meet the requirement for a minimum of 6,000 discharges per year. Therefore, Hadley cannot qualify as a rural referral center.

Hadley meets or exceeds every criteria for designation as a rural referral center with the sole exception of the necessity for 6,000 discharges per year.

Rural Referral Center Criteria

Requirements:	Hadley:
1) 6,000 dismissals	3,356 dismissals
2) Case mix index 1.1172	1.16495 (average current fiscal year)
3) 50% of hospital Medical Staff specialists	47 active Medical Staff - 87% specialists or subspecialists
4) 60% of discharged inpatients reside more than 25 miles from hospital	64% of discharged inpatients are from outside Ellis County (Hadley's home county)
5) 40% of all inpatients must be referred from other hospitals or physicians not on hospital staff	

It seems totally inequitable to assume Hadley should be required to deliver highly specialized, complex care and receive the same rural PPS rate as the much smaller, primary care hospital for which Hadley serves as the referral center.

This inequity is having a devastating negative financial impact on Hadley. In the face of four years of Medicare DRG payment freezes or reductions and continued rural payment rates, Hadley's future is bleak, at best.

An analysis of Hadley's top 25 Medicare DRGs, (representing 65 percent of all their Medicare inpatients), shows Hadley incurs a loss for serving beneficiaries in 23 of those 25 DRGs.

This fiscal year Hadley estimates a Medicare contractual adjustment of $1,679,315. This adjustment (or loss) represents 12.6 percent of Hadley's total revenue. This loss also represents the cost of care provided to Medicare inpatients which was not reimbursed to Hadley by Medicare's current DRG payments. In other words, this $1.6 million represents costs incurred by Hadley which exceeded the DRG payments. A rural referral center designation will not totally eliminate Hadley's contractual adjustment. However, it would result in an estimated $550,000 in additional Medicare payments -- an increase in payment for care which is being provided to Medicare patients.

Only through Hadley's efforts to become as cost effective as possible has it been able to survive to this point. Further cuts would require drastic measures, such as discontinuing services which patients throughout its entire service area utilize, and other similar drastic measures.

These losses are a result of inadequate payment rates and not the result of costs or charges which are too high or exceed the average for hospitals of comparable size. This is demonstrated by using the AHA's Monitrend reports which compare Hadley to other hospitals its size in Kansas and the nation.

Inpatient Revenue/Patient Day

Hadley $495.95 National $536.18 Kansas $494.95

Inpatient Expense/Adjusted Patient Day

Hadley $ 424.99 National $435.03 Kansas $415.30

Contractual losses for 18 Medicare patients at Hadley averaged more than $14,000 per case. In each of these cases, Medicare's Peer Review Organization (PRO) found that all the services provided were medically necessary. The list could be much more extensive, but these 18 cases provide the examples for this hospital. They are examples of the increasingly complex patient needs which require tremendous resources to provide the appropriate care. It shows the inequity of current DRG payments for this hospital.

In the past when attempts have been made to discuss this unique problem and Hadley's justification for being designated as a rural referral center, our Congressional Delegation has indicated no exceptions or modifications of the criteria would be allowed. We have since learned special treatment of certain hospitals has been granted in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). One of COBRA's provisions allows certain rural osteopathic hospitals to become designated as rural referral centers with only 3,000 discharges per year or one half the original requirement. Hadley also meets this newly revised requirement.

It would seem if such a general exception can be made in the regional referral center criteria for these hospitals, that modifications could be enacted to allow Hadley such special treatment.

Besides, we find it difficult to justify the need for any discharge requirement if sophisticated, complex secondary care is being provided and all the other criteria are being met by the hospital.

Financially, Hadley will find it very difficult to continue to provide such sophisticated care to Medicare beneficiaries without being designated as a rural referral center and the resulting increased DRG payments. Without financial stability, maintaining specialized services and continuing to attract and retain physician specialists will be difficult.

The loss of Hadley as a rural referral center would have a devastating impact on health care delivery throughout rural northwest Kansas. Hays' physician specialists and Hadley provide a wide variety of clinical and support services to the hospitals throughout their service area.

In conclusion, Hadley Regional Medical Center is truly a rural regional referral center in every sense of the word. Hadley provides highly sophisticated and complex medical services to Medicare patients throughout a sparsely populated region which represents one quarter of the state of Kansas.

Hadley has met or exceeded every criteria for designation as a rural referral center with the sole exception of 6,000 discharges per year. Because of the very rural sparsely populated area they serve, Hadley will never meet this discharge requirement.

The recent special treatment received by rural osteopathic hospitals shows the Congress' willingness to make an exception in the requirements when justified. An exception for Hadley is certainly justified.

The designation of Hadley Regional Medical Center as a regional referral center would be significantly beneficial to the people in northwest Kansas.

2) Swing-Beds

Swing beds have helped improve the financial condition of small, rural hospitals by allowing them to better utilize their existing resources (fixed costs). Swing-beds have proven to be a valuable service for many rural Kansans - most of whom are Medicare beneficiaries. However, swing-bed hospitals are experiencing difficulties with Medicare participation because of the low payment rate, much delayed and retroactive payment denials, and burdensome reporting requirements. Swing-bed Medicare patients have always had, on an average, higher care needs and, thus, are more expensive to treat. The swing-bed program provides the supportive time elderly people need to return to their optimal functional state of daily living. Medicare's requirements, payment rates for swing-bed services and such as the three-day acute stay eligibility requirement for skilled care, and the continuation of the "spell of illness," continue to hamper the Medicare beneficiaries' access to swing-beds.

In summary, small rural hospitals have a greater risk of not recovering costs under PPS. The costs for outlier cases, in particular, are not recoverable because of the small number of patients served in rural hospitals. As the utilization of inpatient facilities continues to decline, fixed costs must be spread over a lesser number of patients. The threatened financial viability of small, rural hospitals raises significant concerns regarding continued access to quality primary health care services in rural communities. The problem with the rural referral center criteria for a referral center in western Kansas is a problem not only for that hospital but also for the surrounding facilities which send patients to this secondary care center.

Without the small, rural hospital in most rural Kansas communities, there would be a more severe shortage of physician manpower and other health services. Every effort must be made to protect the Medicare beneficiary's access to quality health care services in their communities. Let us not create a crisis which will have to be solved through emergency legislation.

Senator **Durenberger**. Mr. Brockmann.

STATEMENT OF WILLIAM F. BROCKMANN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CAYLOR-NICKEL HOSPITAL, BLUFFTON, IN

Mr. **Brockmann**. Mr. Chairman, Senator Baucus. In my present position, I am the president and chief executive officer of a rural referral center. Our sister organization the Caylor-Nickel Clinic is a Mayo-type multispecialty group practice and our diagnostic capabilities include CAT scanning and magnetic resonance imaging.

Currently, we are reimbursed on the rural referral center rates, which is greater than the standard hospital rural rate and less than the urban rate.

My testimony today is not only on behalf of Caylor-Nickel, but we are joined by 34 other rural referral hospitals. These hospitals are listed on an attachment that I will provide to the committee and include at least two in Montana; Missoula Community Hospital and Kalispell Regional Hospital, three in Idaho, one in Kansas, four in Arkansas, one in New York, one in Texas, four in Oklahoma and two in Iowa.

We are all rural referral centers of 100 to 200 bed size and we all experiencing the same potential problem with the Prospective Payment System. When you passed the rural referral center legislation, you recognized that our costs and services are not typical of the costs and services of a small rural hospital.

You recognized that we provide to rural communities in the United States complex medical services that are frequently available only in large urban hospitals. The law which recognizes rural referral centers and permits them equitable payment under Medicare does not state that a rural referral center has to be a certain specific size, have a certain number of beds or treat a specific number of patients. However, in it's regulation HCFA set a minimum number of 6,000 annual patient admissions for overnight stays.

This 6,000 minimum was based on a hospital's 1981 data, before the current health care cost containment revolution. Since 1981, all hospitals, and especially Caylor-Nickel and the rural referral centers who join us in this testimony, have seen a substantial movement of patients from inpatient to outpatient care. Much of this has been brought about by PPS and the effect is even greater on those of us who provide specialty care.

For example, ophthalmic surgery, which was virtually all inpatient in 1981, is almost never an inpatient procedure today. The same trend is true for orthopedic surgery, pediatric surgery and the like.

In most instances, Medicare now refuses to pay for cataract surgery performed on an inpatient basis. Our hospitals are treating as many patients as they did in 1981, but the difference is that many of those patients are now appropriately and cost effectively being treated on an outpatient basis.

HCFA regulations have not recognized the reductions in hospitalization and the movement toward outpatient procedures. Last year, HCFA eliminated the opportunity for a hospital to measure its

6,000 discharges on the basis of its 1981 data. HCFA is now requiring hospitals to measure the 6,000 discharges from the statistics of it's most recently completed cost reporting year.

Approximately one-fifth of the current rural referral centers, including Caylor-Nickel and the other hospitals which join us in this testimony, no longer treat 6,000 inpatients annually. If the criteria are not changed we will lose our rural referral center status. We cannot afford to lose the rural referral center designation. Rural referral center payments to Caylor-Nickel constituted $1 million out of a $20 million annual budget, 5-percent of our budget. Without the rural referral center payment, last year Caylor-Nickel would have operated at a loss.

In human terms, rural referral center payment is the equivalent of 50 full-time registered nurses. Of course, we could not and would not simply cut 50 nurses from our staff. However, if we were faced with the loss of this payment we would have to choose between cutting direct nursing care or closing programs or eliminating departments.

Other referral centers are faced with the same dilemmas. This situation could have a serious effect on the quality of health care in rural hospitals. If rural referral centers lose their payment they will have to eliminate the sophisticated and complex services which make them referral centers.

Rural patients will be left with no option but to travel even greater distances to cities to receive secondary and tertiary medical care. Not only is it unfair to the patient, but it is unfair to the hospital to reimburse us at a lower rate when we are incurring the same or greater costs.

Rural referral center costs are much higher than the costs of other rural hospitals, because of our complex services. We are required to have a higher component of registered nurses and other professional staff than most rural hospitals. Our malpractice and liability coverage is based on the amount of specialty services that we provide.

We have to pay more for the highly trained technicians who must come and work on our sophisticated technical equipment.

Senator DURENBERGER. You are getting near the end.

Mr. BROCKMANN. Yes.

In summary, we are bearing the expense and treating the patients in rural communities with the high quality of care. We are the type of hospitals that you intended to address when you enacted the rural referral center legislation. However, we are about to become unintended victims because of a regulatory threshhold which is no longer relevant. We are asking that you please put the system back on track, so that we may be able to continue serving as needed rural referral centers. Thank you for the opportunity to testify.

Senator DURENBERGER. Thank you very much.

[The personal statement of Mr. Brockmann follows:]

TESTIMONY OF CAYLOR-NICKEL HOSPITAL

Before the Senate Finance Committee
Subcommittee on Health

We appreciate the opportunity to inform the Committee of the experience of Caylor-Nickel Hospital under the Medicare prospective payment system ("PPS") and to share what we have learned about the experience of other similarly situated rural hospitals.

Caylor-Nickel Hospital is a 201 bed, 501(c)(3) charitable entity located in Bluffton, Wells County, Indiana. The hospital is the primary health care provider of Caylor-Nickel Medical Center. It is closely affiliated with the Caylor-Nickel Clinic, which is a 55 physician multi-specialty group whose members presently constitute the active medical staff of the hospital, and with the Caylor-Nickel Research Institute, a charitable 501(c)(3) institution located adjacent to the hospital. The hospital and clinic maintain satellite and affiliate facilities in Fort Wayne, Ossian, and Dunkirk, in Indiana, and Celina, in Ohio. Caylor-Nickel is 25 miles from the nearest metropolitan area of Fort Wayne, Indiana and is a major regional provider of health care services. Caylor-Nickel's full time active medical staff represents 22 different specialties and subspecialties. The staff is 99.6% Board Certified or eligible in a recognized specialty. Most of the specialists are other than general Family Practitioners, which is the most common community hospital specialty. Our current case mix index, which is the Medicare formula to measure the complexity of medical services performed in a hospital, is 1.1663. This greatly exceeds the median urban index for our region, indicating that Caylor-Nickel is performing more specialized medicine than most urban hospitals in the six state region encompassing Minnesota, Wisconsin, Illinois, Michigan, Indiana and Ohio.

Caylor-Nickel has been in the forefront of those institutions taking an active role in reducing health care costs to the consumer. For the past six years we have had contracts with a federally qualified HMO to provide medical services to the HMO's enrollees. Currently, we are in the process of establishing a preferred provider organization. We conduct utilization review for patients insured through 30 major employers, including Bethlehem Steel, General Motors, United Mine Workers, RCA, Motorola, Bristol-Myers, Honeywell, Corning Glass, and Lincoln National Life, among others. These review requirements are stringent, encompassing preadmission certification, concurrent review, second opinion and other vehicles to deter unnecessary hospitalization. We also conduct similar review services for Blue Cross/Blue Shield of Indiana.

We have increased utilization of noninvasive high technology diagnostics such as CAT scanners, ultrasound and fiber-optic equipment to help reduce the need for hospitalization and invasive surgery. Recently we entered into a joint venture to provide magnetic resonance imaging (MRI) diagnostic services, making us only the second MRI operational in the State of Indiana. Our ambulatory surgery program, which did not exist in 1980, each year has exceeded annual projections. We served 640 patients through the program in FY 1984, 1898 in FY 85 and our FY 86 projection is 2100. Currently, 52% of the surgeries performed at Caylor-Nickel are performed on an outpatient basis. In FY 85, the hospital served over 75,000 outpatients, 10,000 more than in FY 84, and 73% of those patients represented counties in Indiana other than Wells County, as well as the states of Ohio and Michigan.

These developments show continued dedication of efforts to provide increasingly sophisticated diagnostic and surgical services without the necessity of overnight hospitalization.

Although Caylor-Nickel was originally classified as being in an urban area for the purposes of PPS, in 1983, the Wells County area was reclassified as rural. Hospitals in rural areas are paid under PPS at a substantially lower rate than hospitals in urban areas. In 1984 Caylor-Nickel was officially designated a "Rural Referral Center" by the Department of Health and Human Services, in recognition of the fact that its operational characteristics, scope of services and resulting costs are more similar to those of sophisticated urban hospitals than to those of typical rural community hospitals. This Rural Referral Center designation has enabled Caylor-Nickel to receive a higher prospective payment rate than that applicable generally to rural hospitals, although the rate remains below the payment rate applicable to urban hospitals.

This hearing addresses the impact of PPS on the stability of rural hospitals and whether access to quality health care in rural communities is being preserved. Our testimony is based not only on Caylor-Nickel's experiences as a rural hospital under prospective payment, but is drawn from the experiences of other Indiana rural hospitals, both Rural Referral Centers and non-Rural Referral Centers, and other Rural Referral Centers throughout the country. We have been in contact with more than 30 Rural Referral Center hospitals in the 100 to 200 bed size category representing the states of Arizona, Connecticut, Idaho, Iowa, Kansas, Kentucky, Michigan, Montana, New York, North Carolina, North Dakota, Ohio, Oklahoma, Texas, Vermont, Washington, and Wisconsin. We have also consulted the Indiana Hospital Association in order to give this Committee as broad a picture as possible of the special problems encountered by us and by other similarly situated rural hospitals.

Our comments focus on two areas: first we address problems with Rural Referral Center provisions for Referral

Centers with 200 or fewer beds. Second we address the problems stemming from the urban/rural distinction in prospective payment.

I. RURAL REFERRAL CENTER REGULATIONS.

In the original prospective payment legislation, Congress specifically provided that rural hospitals with 500 or more beds would be classified as "Rural Referral Centers" on the assumption that rural hospitals of that magnitude would be providing more sophisticated services than the typical small rural hospital, and should therefore be reimbursed at a higher rate. The Rural Referral Center payment reimburses the hospital at the urban prospective payment rate adjusted to the rural area's wage index and other factors. Congress amended the legislation in 1984, to provide an opportunity for smaller rural hospitals (i.e., 100 to 400 beds) to demonstrate that they are sources of specialized care and should qualify as referral centers. Congress directed HHS to develop alternative criteria to qualify rural hospitals based on the quality and nature of the operating characteristics of a Rural Referral Center. The types of factors Congress directed HHS to focus on in making this determination include: wages, scope of services, service area and the range of medical specialties. None of these factors is specifically size related.

In response, HHS, through the Health Care Financing Administration (HCFA), promulgated alternative criteria for hospitals to qualify as Rural Referral Centers. To qualify under this alternative method, HCFA has required a hospital to meet two mandatory and one of three optional criteria. The two mandatory criteria are: (1) that the hospital demonstrate its complexity of services by showing a specified minimum case mix index, and (2) that it meet a minimum number of discharges. A "discharge" is counted each time the hospital discharges a patient who was admitted for an inpatient (i.e., overnight) stay. Initially, HCFA required the hospital to show that it either had 6,000 discharges in 1981 or 6,000 discharges for its most recent cost reporting period. Subsequently, HCFA eliminated the option to use 1981 data, and is requiring hospitals to demonstrate 6,000 discharges for their most recent cost reporting period, in order to obtain and maintain Referral Center designation.

The problem with this provision is that many rural hospitals in the 100 to 200 bed size category which were able to demonstrate 6,000 discharges in 1981, can no longer do so. Like all hospitals nationwide, these hospitals have had progressive reductions of inpatient admissions and discharges since the onset of prospective payment. These reductions, which are a direct result of the prospective payment system, are even greater in hospitals which have taken an active role in implementing outpatient surgical procedures, obtaining noninvasive high technology equipment and aggressively pursuing cost containment measures.

Approximately one fifth of all currently designated Rural Referral Centers are hospitals such as Caylor-Nickel, in the 100 to 200 bed size category, whose discharges have fallen below the 6,000 threshhold and who will lose their Rural Referral Center status if the criteria are not changed. The reasons for the reductions in discharges are consistent among these hospitals. The primary reason for reduction in discharges is the dramatic increase in outpatient surgeries and other procedures which would have formerly required an inpatient stay. These hospitals have experienced a tremendous shift from inpatient to outpatient over the past five years. For example, Day Kimball Hospital, a Referral Center in Putnam, Connecticut, is seeing virtually a one for one exchange from inpatient to outpatient numbers. Similarly, Community Medcenter Hospital in Marion, Ohio, another Rural Referral Center, has been setting a new outpatient record every month. The Medicare program has mandated some of these changes by requiring that certain procedures, such as ophthalmic surgery, be performed on an outpatient basis. In order to better serve their communities, hospitals have established skilled nursing facilities and home health agencies which care for patients who formerly would have been cared for in a hospital.

It is important to emphasize that these are not hospitals with case-mix problems. These hospitals have no difficulty demonstrating that they perform a broad range of specialty care through a high case-mix index. As the hospitals move the less intricate procedures to outpatient care, inpatient care concentrates on the more complex cases. The end result of this is a higher case mix along with a higher cost to the Rural Referral Center, whose inpatient care is progressively being narrowed to only the most resource intensive types of cases, the cost of which is spread out over fewer patients.

Like Caylor-Nickel, these hospitals are highly specialized providers. For many of us, our entire medical staff is comprised of specialists.

These are clearly the types of hospitals which the legislation for Rural Referral Centers was intended to benefit. They provide needed specialty care on a level more sophisticated than that of many urban hospitals, to patients in the rural areas of our country. They have cooperated with prospective payment and embraced its goals by aggressively promoting outpatient procedures. In so doing their discharges have fallen below the 6,000 threshhold and they will lose their Rural Referral Center designation and the needed funds it provides. Loss of the Rural Referral Center status will have a direct effect on the care our hospitals will be able to provide. We will be required to cut staffing and services, reducing the quality and scope of care in rural communities throughout the nation. Clearly the 100 to 200 bed high specialty Rural Referral Center is caught in a bind. By doing what Congress has asked us to do, we are virtually sealing our own doom.

Furthermore, there is no rational reason for this to occur. The 6,000 discharges criterion was not required by Congress, and does not quantify any aspect of a Rural Referral Center that Congress envisioned. It is merely a number, established by HCFA based on 1981 experience, which has been carried over through 1986 without regard to the intervening circumstances. Between 1981 and 1985, according to data compiled by the Indiana Hospital Association, Indiana hospitals both urban and rural saw an overall 15.9% decrease in discharges. The greatest portion of that decrease, almost 11%, ocurred between 1984 and 1985. In its recent report, the Prospective Payment Assessment Commission (ProPAC) states that "rural hospitals have experienced a substantially greater decline in total admissions during the period 1983 to the first six months of 1985 than their urban counterparts."

The 6,000 discharges requirement is unrelated to any legislative criterion, and has not been revised despite substantially changed hospitalization practices over the past several years. This is exacerbated by HCFA's practice of excluding from its count certain types of discharges, although the patients are legitimate inpatients receiving care in the hospital. If the intent of the discharges criterion is to measure the size of the hospital and the quantity of care it provides, then there is no reason to exclude any discharges.

By not considering the changed hospitalization practices which have moved many former inpatient procedures to outpatient, and by refusing to count certain types of legitimate inpatients, HCFA has jeopardized the status of approximately one fifth of our Rural Referral Centers. In sum, the intended beneficiaries of the Rural Referral Center legislation are being penalized in ways that Congress never intended, and it is incumbent upon Congress to direct the HHS to correct the situation. The seriousness of this problem is further exemplified by the overall urban/rural distinction in prospective payment rates.

II. URBAN/RURAL DISTINCTION.

The problems for Rural Referral Centers are only one aspect of the overall irrationality of the urban/rural distinction in prospective payment. This distinction is apparently based on an assumption that the care provided in rural hospitals is provided at a lower cost than the equivalent care in urban hospitals, an assumption which is simply not true, particularly for those rural hospitals which are Referral Centers.

Lines have been drawn designating certain counties and the hospitals within them as "urban" while contiguous counties are considered "rural" and subject to a substantially lower payment rate. Caylor-Nickel was initially classified as being in an urban region. In 1983, along with nine other Indiana hospitals, we were reclassified as rural. The result of this is that even with the Rural Referral payment, a hospital providing complex specialty care in a rural location receives a lower rate of payment than a community hospital providing fewer services in an urban location, even though that location may be separated by only a few miles from the rural hospital. In the case of Caylor-Nickel and other similar Referral Centers there is repeated and overwhelming evidence of no basis for this distinction. Rural Referral Center hospitals incurred no lesser costs than urban hospitals for the provision of staff, services, supplies and capital. Indeed, in many instances, the cost to the rural hospital is higher.

1. Staffing. Recruitment and retention of medical personnel and support staff for the Rural Referral Center may be more costly than that for the urban hospital. Rural hospitals have difficulty recruiting specialists away from the city. Frequently we must pay expensive "headhunter" fees, and provide salary and benefits greater than those provided by urban hospitals in order to attract and retain medical specialists. Hospitals such as Sid Peterson Memorial in Kerrville, Texas must compete in salary and benefits with large state and veteran's hospitals in San Antonio. The same is true for technical and nursing staff. Although such staff are not generally recruited through the use of headhunters, Referral Centers must compete with urban hospitals for personnel and often must match compensation and benefits. Caylor-Nickel's wage rates for nurses, medical technologists and other medical personnel are comparable to and in some instances higher than the wage rates applicable in Allen County, the adjacent county which is classified as urban. Caylor-Nickel must compete with hospitals in Fort Wayne for personnel. Scott County Memorial Hospital in Scottsburg, Indiana is 30 miles from Louisville, Kentucky and competes with large hospitals there for staffing. Dukes Memorial Hospital in Peru, Indiana is 20 miles from Kokomo and must compete with two to three larger hospitals there for its staff. La Porte Hospital, a Rural Referral Center in La Porte, Indiana, is bordered by two MSAs and is 30 miles from South Bend and 30 miles from Valpariso. La Porte must pay wages comparable to those applicable to the MSA counties. Marion General Hospital, a Rural Referral Center which is the sole hospital in Grant County, Indiana reports that the applicable wage rate in "rural" Grant County exceeds the annual average wage rate in the majority of Indiana's urban counties. This anomaly was addressed by ProPAC in its recent report that PPS "ignores the problems of 'border' hospitals which must compete with urban hospitals for labor."

.. 2. Services. It is also true that services may be no less costly for rural hospitals than for urban hospitals. Utility rates do not vary from urban to rural area. The cost of repair personnel to work on technological equipment is no lower, and in fact is higher, because the repair companies are usually city based. Hospitals such as Memorial Hospital of Southern Oklahoma in Ardmore, Oklahoma, must pay someone for the 60 mile drive from Oklahoma City to work on an x-ray machine.

3. Supplies. Our experience shows that supplies are no less costly for rural hospitals. In fact, urban hospitals which tend to be larger are often able to obtain volume discounts which give them an advantage over rural hospitals. Rural hospitals which are able to obtain volume discounts for themselves by membership in group purchasing organizations pay no less for the supplies than do urban hospitals in the same organization. In fact, rural hospitals will pay even more in these circumstances because of the cost of freight to the rural area.

4. Capital. Interest rates for Rural Referral Centers have been no lower than for urban hospitals. In fact, they may be higher if the rural hospital is perceived as a greater risk due to its small size. Distinctions between urban and rural capital payment rates are unjustified.

In sum, the entire premise for the differential in payment between urban and rural hospitals is flawed. The major expenses of the hospitals are similar and may be greater for rural hospitals such as Rural Referral Centers which provide complex services. The result is an inequitable two-tiered system in which Medicare pays more to a primary care hospital that provides fewer services than to a secondary or tertiary care hospital providing broader and more intensified services, simply because the former is classified an urban hospital and the latter is classified rural.

III. CONCLUSION.

In summary, rural hospitals, in particular Rural Referral Centers of 200 or fewer beds, are being seriously threatened by Medicare policies regarding Rural Referral Center designation and differentials in urban and rural payment rates. The access to high quality health care provided by small Rural Referral Centers may soon be substantially cut off because of unreasonable policies.

Thank you for the opportunity to testify. We are continuing to collect data from Rural Referral Centers and will supplement the record with information as it becomes available. We will be pleased to supply the Committee with any further information it may require.

RURAL REFERRAL CENTERS SUPPORTING THE TESTIMONY OF CAYLOR-NICKEL HOSPITAL

BEFORE THE SENATE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH
HEARING ON RURAL HOSPITALS UNDER MEDICARE
MAY 9, 1986

Chickasawba Hospital
Blytheville, Arkansas

AMI National Park Medical Center
(Ouachita Memorial Hospital)
Hot Springs, Arkansas

Warner Brown Hospital
El Dorado, Arkansas

Union Medical Center
El Dorado, Arkansas

Day Kimball Hospital
Putnam, Connecticut

Fawcett Memorial Hospital
Port Charlotte, Florida

Mercy Medical Center
Nampa, Idaho

West Valley Meeical Center
Caldwell, Idaho

Bannock Memorial Hospital
Pocatello, Idaho

St. Mary's Hospital
Galesburg, Illinois

Caylor-Nickel Hospital, Inc.
Bluffton, Indiana

St. Joseph's Mercy
Mason City, Iowa

Ottumwa Hospital
Ottumwa, Iowa

Halstead Hospital
Halstead, Kansas

Ephraim McDowell Memorial
Danville, Kentucky

Pattie A. Clay Hospital
Richmond, Kentucky

Community Health Center of
  Branch County
Coldwater, Michigan

Alpena General Hospital
Alpena, Michigan

Missoula Community Hospital
Missoula, Montana

Kalispell Regional Hospital
Kalispell, Montana

The Mary Imogene Bassett Hospital
Cooperstown, New York

Rutherford Hospital, Inc.
Rutherfordton, North Carolina

Johnston Memorial Hospital
Smithfield, North Carolina

Albemarle Hospital
Elizabeth City, North Carolina

St. Joseph Hospital
Minot, North Dakota

Community Medcenter Hospital
Marion, Ohio

Valley View Hospital Center
Ada, Oklamoha

Jackson County Memorial Hospital
Altus, Oklahoma

Memorial Hospital of Southern
Ardmore, Oklahoma

Grady Memorial Hospital
Chickasha, Oklahoma

Sid Peterson Memorial Hospital
Kerrville, Texas

SW Vermont Medical Center
Bennington, Vermont

St. Mary's Medical Center
Walla Walla, Washington

Skagit Valley Hospital
Mt. Vernon, Washington

St. Michael's Hospital
Stevens Point, Wisconsin

Senator DURENBERGER. Max.

Senator BAUCUS. Mr. Brockmann, I appreciate your point about rural referral centers. Particularly, I appreciate that you mentioned Missoula, it is true. We have a couple referral centers in Montana and the 6,000 standard is causing a severe problem. I think that the Missoula hospital stands to lose a $150,000 if it is kicked out. These hospitals were referred to earlier as honorary urban. If it is kicked out of an honorary urban status, as I said, the Missoula Community stands to lose $150,000, which is quite a bit for a hospital that size.

What recommendations do you have? What should the standards be?

Mr. BROCKMANN. There are a number of options that could address this particular problem. One is some type of formula to take into account the outpatient activities that these hospitals are experiencing. One of the other problems associated, someone mentioned earlier, I believe if was Senator Durenberger, about the mental health services. We expanded our psychiatric service at our hospital and it now constitutes one-third of our census. But those discharges are not included in the count of 6,000 discharges, because it is an exempt unit.

Senator BAUCUS. Where did they come up with that number of 6,000. You said it was based on 1981 data, still it does not explain where 6,000 came from. Senator Dole asked, "What is so magic about 6,000." Do you know what was so magic?

Mr. BROCKMANN. We have the same question, and of course with the trend—as an administrator, I am caught in a bind. I see $1 million of reimbursement on one hand, that I stand to lose, but on the other hand the good cost effective care in many of these cases is switching over to outpatient. I think this problem should be addressed, the 6,000 should be eliminated or they should go back to the 1981 standards to allow administrators to pursue aggressively the cost effective outpatient care. But right now it is truely a disincentive, the way it is set up.

Senator BAUCUS. A question, Dr. Fickenscher, how do we resolve this dilemma? As I see it, right now under the two-tier system, small rurals are getting taken to the cleaners, frankly. I think it was Congressman Tauke who said that if we went to a uniform system for hospitals of all sizes, there would probably be a windfall to small rurals.

How do you resolve that dilemma?

Dr. FICKENSCHER. Well, I think that does represent a major problem and our census and our organization is that some sort of regional system may be an effective approach towards the two-tier system, because, yes there may be windfall. But as it stands right now, many, many of the world facilities are in major dilemma as a result of the two-tier system. And, are losing out quite significantly and I think it is evident from the closure of facilities in the last year. They are the ones that are suffering.

Senator BAUCUS. Thank you.

Senator DURENBERGER. Gentlemen, thank you very much for your testimony, I appreciate it very much. We have five witnesses remaining and we will call all five of them up together. Olaf Kaasa, who represents the American Association of Retired Persons, Minnetonka, MN; Sterling Hayward, member of the board of directors of the American Medical Peer Review Association, Billings, MT; Eugene Beck, director of the office of rural health, Intermountain Health Care, Inc., Salt Lake City, UT; Frank Trembulak, senior vice president and treasurer, Geisinger Foundation, Danville, PA; Carol Kiecker, regional vice president, Health Central Systems, Minneapolis, MN.

All of your statements will be made part of the record as will the previous witnesses and you may proceed to summarize those statements beginning with Mr. Kaasa.

Senator BAUCUS. Mr. Chairman, before you begin, I would like to just introduce a Dr. Hayward.

Senator DURENBERGER. Go right ahead.

Senator BAUCUS. Dr. Hayward is from Billings, MT. In fact, Dr. Hayward has been one of the most valuable resource persons I have known in this area as long as I have known him. Dr. Hayward was present at the creation of the PSRO's. As one of the authors of the system, he has been very diligent and very helpful. In fact, he is one of the most helpful persons I know in helping us refine all the peer review problems. I must say, too, that it is another deregulation that almost prevented him from making it here today, airline deregulation. We do not have the very best air service to Montana, it is comparable to the problems of the some of the health delivery services we face in rural America. Sterling, we are very honored to have you here.

Dr. HAYWARD. Thank you very much, sir.

Senator BAUCUS. You bet.

Senator DURENBERGER. Olaf.

STATEMENT OF OLAF KAASA, MEMBER, NATIONAL LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS, MINNETONKA, MN

Mr. KAASA. Senator Durenberger, Senator Baucus, I appreciate very much being here.

My name is Olaf Kaasa and I am on the National Legislative Counsel for the AARP. I am here representing the consumer on behalf of AARP's 22 million members.

One of the greatest concerns of older Americans is affordable health care. Our recommendation to you is that Medicare policies as they apply to rural hospitals should be based primarily on the needs of the rural elderly for access to cost efficient and quality health care.

We know many of the hospitals are in poor financial condition but their problems are not solely attributed to Medicare's prospective payment system. Hospitals are vulnerable due to their small size, low occupancy rate and certainly, in many areas of the country, the farm economy.

And therefore, we think that it is necessary that we consider the consumer, not necessarily the provider. Because, as we know, health care is a very difficult problem for older people. One of their major concerns, one of our major campaigns for our association at the present time is to try every possible way we can to bring about cost containment.

One of the main expenses in health care is unoccupied hospital beds. Now, if there are many in the rural area then we think the policy for Medicare should be based on elderly, the consumer, and not necessarily on the fact that we have a hospital in a small community that we would like to see survive.

The information that we have tells us that less than half of all local residents are served by rural hospitals. The rest of the local residents go someplace else for their services. Why did they go there?

Many of the answers that we need must come from HCFA-funded studies, as noted here, this morning. We have a staff of people ready to work on that report and tell us just exactly what happens.

We know that there are a certain percentage of rural people that prefer to go someplace else, in spite of their local facilities. Therefore, we think you have to look at requests for financial assistance by troubled rural hospitals very, very carefully to be sure that the operation of the Medicare policy conserves the trust fund. The trust fund has got to be used so that if the best way to provide hospital care is to bring people someplace else, it has got to be done, in spite of how we feel about rural America. I think that is the thrust of AARP's position.

The recommendations we have are: No. 1, to urge the Health Care Finance Administration to release its reports—we are very dependent on that. And, second, the Medicare Quality Assurance Act S. 2331 should be passed in order to enhance beneficiaries' rights and empower the PRO's to review entire episodes of care and outpatient surgery.

No. 3, the part A deductibles should be recalculated so Medicare beneficiaries are not unfairly burdened with out of pocket costs. You know the ever escalating cost of the deductible amount for the consumer works a great hardship, especially so on rural elderly.

Existing Medicare conditions of participation should be retained for non-JCAH hospitals and HCFA should fund studies to evaluate rural hospitals in terms of their role in assuring access to cost effective, quality care in light of beneficiary health care needs.

Data from these studies should guide Medicare policies in rural hospitals.

Thank you very much.

Senator DURENBERGER. Thank you, Olaf.

[The prepared statement of Mr. Kaasa follows:]

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WILLIAM J WILKINS MINORITY CHIEF COUNSEL

United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510

May 15, 1986

Olaf Kaasa
Member, National Legislative Counsel
American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20049

Dear Mr. Kaasa:

To follow-up on your testimony at the May 9, 1986 Subcommittee on Health hearing on the status of rural hospitals under the Medicare program, Senator Durenberger would like you to answer the attached questions.

Your response should be typed on letter-size paper and double spaced. To meet our printing schedule, please provide your answer no later than June 6, 1986. Send the response to:

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, D.C. 20510

If you have any questions, Ms. Salmon may be reached at 202/224-4515.

Sincerely,

EDMUND J. MIHALSKI, C.P.A.
Deputy Chief of Staff
for Health Policy

Follow-Up Questions from Senator Durenberger for Olaf Kaasa

1. In your testimony, you assert that the health care needs of the rural elderly are central to decisions concerning continuation, conversion, or closure of hospitals. You also state that there is no evidence to sustain the claim that every rural hospital is essential for access to care. In your opinion, who should make the decisions regarding continuation, conversion, or closure?

2. Many rural hospitals have attempted to cope with declining inpatient revenues by diversifying their services and providing care on an outpatient basis. You have expressed concern about this trend in your statement. What specific information do we need to know about surgical procedures done on an outpatient basis?

(C0555)

AARP

May 23, 1986

SHANNON
FOR THE RECORD

Mr. Edmund Mihalski
United States Senate
Committee on Finance
Senate Dirksen Office Building
Washington, D.C. 20510

Dear Mr. Mihalski:

Mr. Kaasa asked me to respond to your letter of May 15, 1986. AARP is pleased to submit additional information for the record concerning the treatment of rural hospitals under Medicare.

Our answers to your questions are attached.

If you need any further information about AARP's views, please contact me at (202) 728-4859.

Sincerely,

Shelah Leader, Ph.D.
Institute of Public Policy

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
Vita R. Ostrander *President* Cyril F. Brickfield *Executive Director*

Follow-Up Questions from
Senator Durenberger for Olaf Kaasa

Q. In your testimony, you assert that the health needs of the rural elderly are central to decisions concerning continuation, conversion, or closure of hospitals. You also state that there is no evidence to sustain the claim that every rural hospital is essential for access to care. In your opinion, who should make the decisions regarding continuation, conversion, or closure?

A. With respect to the question of who should decide whether a particular rural hospital should remain in business, close, or convert to another use, AARP's position is as follows:

AARP has long believed that a strong, consumer-oriented health planning process could effectively address the nation's dual needs to provide basic access to care and control cost. However, health planning systems have not received the financial or political support they need in order to realize their potential.

Absent a strong planning agency, decisions regarding the status of particular hospitals will probably be made on an ad-hoc basis.

AARP believes that the Medicare trust funds should not be tapped to rescue failing hospitals unless there are strong, objective, and reliable data showing that preservation of the hospital(s) is absolutely essential to the health care needs of local consumers.

We urge Congress to resist the pleas of rural hospital administrators for special fiscal relief from Medicare until it is possible to evaluate these requests from the point of view of the public to be served.

In our view, HCFA has been derelict in its duty to provide Congress and the public with the information needed to make sound policy decisions regarding rural hospitals. Once such information is available, AARP would be happy to work with members of Congress to forge a reasonable Medicare policy on rural hospitals.

Q. Many rural hospitals have attempted to cope with declining inpatient revenues by diversifying their services and providing care on an outpatient basis. You have expressed concern about this trend in your statement. What specific information do we need to know about surgical procedures done on an outpatient basis?

A. In order to properly evaluate the recent and growing trend toward outpatient surgery, we need to know:

a. The incidence rate for outpatient surgery on Medicare beneficiaries in hospital-based and freestanding ambulatory surgical centers;

b. The most frequently performed procedure in both settings;

c. The beneficiary's out of pocket costs for these procedures;

d. The amount of beneficiary liability due to unapproved procedures;

e. Morbidity and mortality rates adjusted for patient mix, case mix, and severity for leading procedures in both settings;

f. The appropriateness of these procedures;

g. Post-operative hospital admission rates due to complications associated with the ambulatory surgery;

h. Home health care utilization rates associated with ambulatory surgery; and

i. The types of out-patient surgery being performed at very small hospitals (50 beds and less) as well as the morbidity and mortality rates for these procedures.

TESTIMONY OF THE
AMERICAN ASSOCIATION OF RETIRED PERSONS
BEFORE THE
SENATE FINANCE COMMITTEE ON
RURAL HOSPITALS UNDER THE MEDICARE PROGRAM

May 9, 1986

Senator Durenberger and members of the committee, my name is Olaf Kaasa and I am a member of the American Association of Retired Persons National Legislative Council. On behalf of the 22 million members of the American Association of Retired Persons (AARP), I am honored to be here to discuss rural hospitals and Medicare's prospective payment system.

Introduction

Our acute care health delivery system is characterized by excess capacity and maldistribution of resources. AARP's basic health policy goals are to control health care costs while maintaining access to quality care. We strongly believe these goals should be the basis for Medicare policies with respect to rural hospitals. We start from the premise that the needs of consumers are more important than the needs of hospital administrators. Any decisions regarding the survival of a particular hospital or a category of hospitals should be made with reference to the impact on consumers of closure, conversion, or maintenance of a hospital.

Rural Elderly

The health care needs of the rural elderly are of central importance to any discussion of rural hospitals.

According to the 1980 census, about 11% of the rural population consists of persons aged 65 and older. Rural hospitals are heavily dependent upon the elderly as a source of patients. Otherwise put, total Medicare admissions to rural hospitals have long comprised a higher percentage of total admissions than they have for urban hospitals. In 1984, 40% of rural hospital admissions were for Medicare patients compared with 34% for urban hospitals (1986 Annual Report of the Prospective Payment Assessment Commission, (PROPAC), April 1, 1986). Rural hospitals' dependence on elderly patients increased between 1980 and 1984.

Rural hospitals have also been more dependent than urban hospitals on Medicare patients when measured as a percentage of total patient days. In 1984, 46% of days of care in rural hospitals were paid for by Medicare, compared with 43% of urban hospital days of care. Because rural hospitals depend so heavily on Medicare as a revenue source, changes in reimbursement methods, fee schedules, and utilization by the elderly disproportionately affect the viability of rural hospitals. Seventy-three percent of rural hospitals in 1984 had 100 beds or less. Small hospitals are especially vulnerable to slight changes in revenue and occupancy and cannot easily absorb losses. That is, small hospitals have fewer available coping mechanisms with which to respond to market changes.

Rural Hospitals in Jeopardy

Administrators of rural hospitals have, since 1984, requested additional financial assistance from the Medicare program on the grounds that the prospective payment system and declining Medicare admissions rates threaten their financial stability and could result in their closure.

While there is considerable evidence that rural hospitals are financially vulnerable, it is much less clear that Medicare is to blame.

Studies show that small hospitals with lower occupancy rates are more likely to close than others. This propensity to close was found to hold true between 1960 and 1980 (see for example, L. Kennedy and B. Dumas, "Hospital Closures and Survivals", Health Services Research 18:4, Winter 1983). But, the American Hospital Association found that 57% of the community hospitals that closed in 1985 were in large metropolitan areas. (Hospitals , April 5, 1986, p. 93).

Even before prospective payment was instituted, rural hospitals were in trouble. Their average length of stay for elderly patients was lower and they had lower occupancy rates (61%) in 1980 than did urban hospitals (72% occupancy) (PROPAC Annual Report). Furthermore, small (less than 100 beds) rural hospitals had worse operating margins between 1980 and 1982 than did other hospitals.

Fiscal distress due to declining occupancy in rural hospitals is partly traceable to the 1982-83 farm crisis. For example, during that period, rural hospitals in Kansas experienced a 37.4% occupancy rate. And, the American Hospital Association reported that in 1983, overall declines in admission were greater for those under age 65 and attributed lower admissions to bad weather, a poor economy, unemployment, and Medicaid cutbacks (Hospitals, June 1, 1984, p. 20).

All of this points to a conclusion that the fiscal crisis confronting rural hospitals can not be laid only at Medicare's doorstep. But, all the indicators of fiscal health clearly show that rural hospitals are in a much weaker condition than are urban hospitals, partly because rural hospitals tend to be smaller and to have overall lower occupancy rates.

PPS Effects

Rural hospitals report a sharp decline in admissions since 1983. Between 1983 and 1984, rural hospitals experienced a 5.7% decline in occupancy compared with a 2% decline for urban hospitals. And, between January 1984 and June 1985, small (less than 50 beds) hospitals had a 15.7% decline in admissions.

But, rural hospitals in general improved their operating margins between 1983 and 1984 and ended the year with the best operating margin reported since 1980.

One way many rural hospitals have learned to cope with declining inpatient census is to diversify their services and provide them on an outpatient basis. In 1985, 15% of rural hospitals increased the use of outpatient services. In 1984, even hospitals with less than 50 beds performed over 70,000 ambulatory surgical procedures. Hospitals with fewer than 100 beds account for nearly a third of all rural ambulatory surgery. (1984 Annual Survey of Hospitals, American Hospital Association). We at AARP are concerned about the trend toward outpatient hospital services because of the high Medicare beneficiary co-payments required and because PROs do not scrutinize outpatient hospital services for quality and necessity. We are especially concerned about the surgical procedures done at very small hospitals and want to know more about the types of surgery being done and the resulting mortality and morbidity rates for these procedures. Hospital-based outpatient cataract surgery (a common Medicare procedure) has both a higher total cost and higher cost to the beneficiary than does the same procedure when performed on an inpatient basis. Policy makers and beneficiaries alike need to know more about the effects of outpatient services on the cost and quality of care provided by rural hospitals.

Furthermore, many rural hospitals are benefitting from special protections under the PPS system. The protections are afforded to rural hospitals classified as "sole community providers" and "referral centers". These special protections are intended to preserve access to care.

Several Congressionally mandated studies of the effects of PPS on rural hospitals in general, as well as on sole community providers and referral centers in particular, have been completed but withheld by the Health Care Financing Administration (HCFA).

These studies may provide valuable data with which to evaluate how rural hospitals are faring. It makes little sense to withhold these studies or to devise new payment policies absent data. We urge HCFA to release these studies immediately so that we can factor their findings into policy debates.

Types of Rural Hospitals

Rural hospitals are not homogeneous. HCFA defines a rural hospital as a facility located outside of a county in which there is a population center with 50,000 people. Some rural hospitals may be quite near one or more other hospitals with which they compete. Others may be in a sparsely populated county but adjacent to an urban area in another county. Rural doesn't always mean isolated.

In fact, a survey of rural residents found that 30% prefer to travel for medical care. (Modern Healthcare, December 6, 1985, p. 82). The point is that not all rural hospitals are essential to maintain access to care.

The vital role of maintaining access is performed by a special subset of hospitals - both urban and rural - designated as sole community providers and/or referral centers.

Only 345 (or 12.8%) of the nation's 2,705 rural hospitals are sole community providers. One hundred and forty hospitals (5.2% of the total) are referral centers. Fourteen hospitals carry both designations.

By definition any hospital fifty miles from another short stay acute hospital is eligible for sole community provider status. In addition, hospitals can receive this designation even if they are less than fifty miles from the nearest hospital if weather or topography often make it difficult to reach another hospital.

Sole community providers remain at 75% hospital specific payment rates under PPS. This permits hospitals with higher costs to receive higher payments under PPS.

In addition, when sole community providers experience a decrease in total discharges that is 5% higher than the previous cost reporting system, they can receive increased PPS payment if the decline is due to extraordinary circumstances beyond the hospital's control (42 C.F.R. 412.92).

There are several unanswered questions about this aspect of PPS. One study found that only 80% of eligible hospitals have received sole community provider designation (D. Farley, "Sole Community Hospitals", DHHS publication No. (PHS) 85-3348, March 1985, p. 17). We don't know how many potentially eligible sole community providers have not sought this designation because their expenses are the same as or less than the national rate. These hospitals will benefit from the move to a national rate.

Furthermore, few hospitals have availed themselves of the opportunity to be compensated for declining patient discharges. Thus far, HCFA has dealt with only four hospital requests for compensation (two approved, 1 denied, and 1 returned for more information). Four more applications are pending. Again, HCFA does not know why so few requests have been filed.

Based on one government study, (Farley, Ibid.) we can make the following generalizations about sole community providers:

o Their patients have shorter lengths of stay than those at other rural hospitals. The same is true of their Medicare patients;

o Medicare patients constitute a smaller percent of their total admissions than for other rural hospitals;

o They have a much lower occupancy rate (47%);

o Their labor costs, adjusted for case mix, are lower and they employ fewer full time staff;

o They serve a younger, predominately white, and healthier population than that served by other rural hospitals. Mortality and morbidity rates for their population are generally lower than for those served by similar rural hospitals. They treat less severe case mixes than other rural hospitals.

By definition, referral centers are located in a rural area, have at least 500 beds, and half of their Medicare patients are referred from another hospital or from physicians not on staff. In addition, 60% of the Medicare patients treated must live more than 25 miles away and 60% of the hospital's services to Medicare beneficiaries are provided to those who live 25 miles away. Once designated, referral centers are paid on an urban rate adjusted by the hospital's area usage index.

Access

As noted above, Medicare already includes some financial protections for hospitals that serve a vital role in providing access to care for isolated communities.

There is no evidence to sustain a claim that every rural hospital is essential for access to care. In fact, rural hospitals often serve less than half of the local residents; the rest prefer to go elsewhere for care (Modern Healthcare, September, 1984).

We simply don't know enough about the services provided by rural hospitals in relationship to residents' needs. For example, we need to know about available transportation to alternate sources of care. The 1980 Census found that 20% of rural older householders do not have a car. Twenty-six percent of older rural households living in areas populated by 1,000 to 2,500 residents have no car. We certainly need to assure access to care for these people. But, 80% of older households do have private transportation and it might be in their interest to travel further if the care provided is superior to that which is locally available.

We also need to compare the reasons for Medicare admissions with the capabilities of rural hospitals. How well do these hospitals treat emergency cases? Would consumers be better off going elsewhere for elective procedures? We simply don't know. Many advocates of rural hospitals argue that they are essential to the continued availability of physicians. They claim that local doctors would leave the area if the hospital closed. We know of no evidence to support that claim. HCFA should be studying these questions.

Since the proportion of elderly poor and near poor persons is higher in non-metropolitan areas than it is elsewhere, we are concerned that the rapidly rising Part A deductible could effectively deter rural elderly people from seeking needed hospital care. According to the U.S. Census Bureau, 27% of older Americans living in non-metropolitan areas in 1983 had incomes below 125% of the poverty line. We need to know whether the Part A deductible had a disproportionately negative effect on access to care for these Medicare beneficiaries.

Quality

While there are no published studies of the quality of care provided by rural hospitals, there are some disturbing signs that small rural hospitals may not be up to snuff. One-third of rural hospital administrators surveyed said that the quality of care given to Medicare patients worsened since the introduction of prospective payment. (*Modern Healthcare,* December 6, 1985, p. 86).

An eight-state survey of lab technicians found that 23% of lab personnel in hospitals with less than 100 beds are not certified. Forty percent of the non-certified lab technicians working in the smallest hospitals have only a high school diploma and need basic training in their job. (Modern Healthcare , September, 1984, p. 178).

We are also deeply concerned about the problem of premature discharges of Medicare beneficiaries in rural hospitals. While the Inspector General's report on "Inappropriate Discharges and Transfers" dated March 1986 does not indicate the proportion of questionable discharges attributable to rural hospitals, discharges in rural areas may raise greater problems for beneficiaries and their family. First of all, small rural hospitals are less likely to have a department of social work staffed with qualified discharge planners. In 1982, only 51% of rural hospitals offered social work services compared with 78% of other community hospitals (Farley, Op. Cit, p. 9). Secondly, home health care agencies are less available in rural than urban areas. We fear that Medicare patients may be discharged from rural hospitals quicker and sicker into a no care zone.

We are further alarmed by HCFA's persistent intention to issue new and substantially weaker Medicare conditions of participation for non-JCAH accredited hospitals. In 1982, only 58% of rural hospitals had been accredited by JCAH, compared to 80% of other community hospitals. (Farley, Op. Cit., p. 6). AARP is a member of a coalition seeking to maintain the existing stronger conditions of participation because we are convinced that the proposed new conditions will weaken quality standards, jeopardize consumers, and send the wrong signal to the hospital industry. It is outrageous that the Department of Health and Human Services has basically ignored more than 36,000 comments from 85 professional medical and consumer groups submitted in response to the proposed new conditions of participation. The preponderance of these comments were negative, yet the Department has been largely unresponsive to the sincere quality and safety concerns of those who oppose the issuance of these new and weaker regulations.

Furthermore, since HCFA has failed to issue Congressionally mandated studies on the performance of rural hospitals under PPS, it seems unreasonable to revise Medicare regulations absent reliable data on their cost and quality consequences.

AARP Recommendations

AARP believes that rural hospitals should be evaluated on the basis of their role in maintaining access to care and on their demonstrated ability to deliver cost-efficient quality care.

Consumers need objective and current information about the cost and quality of care offered by nearby rural hospitals in comparison with care provided by alternate sources of care. In light of the foregoing considerations, AARP makes the following recommendations:

1. AARP concurs with PROPAC's recommendation #11 that HCFA should quickly complete and issue its mandated studies of rural hospitals under PPS (p. 38). We also agree that data from these studies are an essential prerequisite to considering changes in the payment system.

2. AARP concurs with PROPAC's recommendations #15-19 concerning beneficiaries' rights, PRO review of episodes of care and outpatient surgery as well as recalculating the Part A deductible. Consequently, AARP urges the rapid passage of the Medicare Quality Assurance Act (S. 2331) as an excellent means to implement these PROPAC recommedations.

3. Existing Medicare conditions of participation for non-JCAH hospitals should be retained.

4. HCFA should fund studies to evaluate rural hospitals in terms of their role in assuring access to cost-effective quality care in light of beneficiary health care needs. Data generated by these studies should be used to evauate requests by hospital administrators for additional Medicare payments.

Senator DURENBERGER. Dr. Hayward.

STATEMENT OF DR. STERLING HAYWARD, M.D., MEMBER, BOARD OF DIRECTORS, AMERICAN MEDICAL PEER REVIEW ASSOCIATION, BILLINGS, MT

Dr. HAYWARD. Thank you, Mr. Chairman. Thank you Senator Baucus for inviting me to testify before this committee. It is a very important subject for the State of Montana. You will see a little map over here. I think I can dispense with this business of the distance by a small demonstration.

This is Montana, this is Wyoming—note that with Alzada at W.D.C., Yaak is North of Chicago in Lake Michigan. That will give you a little idea of what rural health care is all about as far as distances are concerned.

Thank you.

Senator DURENBERGER. Very well done.

Dr. HAYWARD. Senator Baucus did talk a little bit about my experience. I started about 14 years ago, actually, with the physician peer review, Montana Foundation for Medical Care. One of the other experiences that I had during the time I was on the board and president and so on was serving as the physician member of Montana's hospitals rate review board.

The instance that I am going to relate to you has to do a lot with the pride that small communities have in their hospitals. The process of rate and review system was for the hospital to present a perspective budget, it was sent into the central office where our executive director reviewed it, made comments, sent it back to the hospital and then the individual hospitals were invited to come in for a discussion and review of recommendations, and so on.

This involved a very small, very remote community in Montana. When the administrator came in, she had fire in her eyes. She was very uncommunicative, gave us a couple letters, one was from the physician, one was from their president of their board of directors. Essentially the comments that the executive director had made, one referred to the physician's type of practice and the physician thought he was being criticized. The other thing that was brought up and has been alluded to many times is the cost of retaining or maintaining district hospitals and he wondered if the citizens of that particular county were aware of how much it was costing to keep that facility afloat. Well, after some deliberation it was obvious the only way we could settle this problem was to got that community, meet with the board and the physician and their administrator on a face-to-face type confrontation.

Three of us were elected to go meet, I was the physician, executive director and the one of the administrators of one of the local hospitals in Billings. We flew down, the executive came from Helena. They picked us up in Billings, we flew down, we landed on a small gravel strip, that was a little hairy. We were escorted to the hospital, the parking was full of four-wheel drive, mud spattered vehicles. We were escorted into the board room—which happened to be the cafeteria and it was real hostile there, too. Anyway to make a very long story short we did not make this presentation to them.

No. 1, I explained to the physician that his practice pattern was appropriate. No. 2, the board of directors president essentially told us, well they asked—the first question they asked was, Could we close their hospital? We said no, we do not have this authority.

The board president stated, well in that particular case why don't you butt out, as far as we are concerned we want this hospital here. We do not care how much it costs, in other words, bug off, big boys.

So, we apologized and left. I thought maybe we were going to a little old fashioned necktie party, when we first walked into that place.

I would be very happy to stop now and very happy to answer questions later on.

Senator **Durenberger**. Thank you, Dr. Hayward.

Eugene Beck.

[The prepared written statement of Dr. Hayward follows:]

STATEMENT OF THE AMERICAN MEDICAL PEER REVIEW ASSOCIATION

BEFORE THE SENATE COMMITTEE ON FINANCE

SUBCOMMITTEE ON HEALTH

ON

THE EXAMINATION OF RURAL HOSPITALS

UNDER THE MEDICARE

PROSPECTIVE PAYMENT SYSTEM

Presented by: Sterling Hayward, M.D.
AMPRA Board Member

May 9, 1986

Mr. Chairman, I am Dr. Sterling Hayward, member of the Board of Directors of the American Medical Peer Review Association (AMPRA) which represents physician-based medical review organizations including 53 Peer Review Organizations (PROs) under contract to Medicare. I also sit on the board of Montana-Wyoming Foundation for Medical Care. On behalf of our Association, I want to thank you for this opportunity to participate in these hearings and to share with you the experience of our members conducting medical review in rural settings.

As you know, the delivery of health care services in a rural environment is complicated by a number of factors that must be taken into account by any peer review program. Quite obvious are the dispersion of the population and the geographical barriers that create access problems for beneficiaries to secure the services of practitioners and institutions. In addition to problems of isolation, there are also limitations that arise as a result of shortages of professionals and facilities. Finally, there are problems related to provider reimbursement, particularly the urban/rural differentials in the Medicare prospective payment system (PPS) and the recent freezes on provider payments.

All of us recognize that the challenge of serving the health care needs of our rural residents requires flexibility and special considerations. Historically, government has recognized this need and explicit policies and programmatic efforts were established to improve patient access to needed care. The advent of Medicare and Medicaid eliminated many economic barriers to medical care for the elderly. The Hill-Burton program permitted many rural communities to construct acute care facilities when local resources were limited. The federal government and the states have invested significant resources to aid in the construction of other types of rural health care facilities and in the recruitment and support of physicians and other health professionals. The Medicare program was revised in 1977 to help encourage the participation of rural health clinics to better serve some of the primary care needs of our older rural residents. The area health education centers program under the Public Health Service Act has also helped to bring advancements in medical practice and technology to the delivery of services in rural areas.

Yet, these programs and policies have not overcome all of the obstacles facing our rural health system. There are still shortages of professional personnel, particularly in the medical specialties. In some areas, there are especially serious gaps in the availability of post-acute services, both institutional and in the home.

With still so much to be accomplished to assure patient access to high quality medical services in our rural communities, we have recently entered the age of health care cost containment. No longer are the concerns for quality and access driving health policy decisions as they were two decades ago. Instead, national health care policy is being dictated by the federal deficit and the need to reduce/stabilize government expenditures in health care.

The advent of Medicare prospective payment and the current inclination of Congress to freeze provider payments are the most visible examples of these new cost containment strategies. While it is true that encouraging greater efficiency in health care delivery may improve the quality of care, AMPRA must express concerns about the future of PPS in an era of severe constraints on the federal budget. We recognize the serious problem posed by the growing federal deficit, but we believe that continuing reductions in Medicare payments below current levels will produce compromises in both accessibility and quality of care. It is difficult, if not impossible, to predict in advance at what level cuts will adversely affect access of quality. The threshold of these effects will, of course, vary according to individual circumstances. Nonetheless, we believe that, for some hospitals, further declines in Medicare payment threatens closure of all or part of their operations. There is a risk associated with substantial cuts in payment and one we must be prepared for.

No where is the risk greater than in our rural communities. Any change can upset a delicate balance of community needs and available resources. Many of the potential risks to quality of care caused by prospective payment will surface first in our rural communities. PPS has caused dramatic changes in the use of hospital services. The effects of declines in hospital admissions, in length of stay, and occupancy rates can be particularly devastating in a small rural hospital that cannot spread fixed costs across high patient volume. These changes combined with the effect of frozen or reduced payments, the inadequacy of outlier payments, the inequity of urban/rural rate differentials pose serious threats to the financial viability of rural hospitals that are often the sole provider of care for a large geographic area.

While these new economic pressures on rural hospitals reflect a basic restructuring of the medical care delivery system away from dependence on acute care facilities, these changes must be carefully managed to insure that patient care and patient access to needed services are not jeopardized. The long term challenge is to develop a more appropriate mix of community resources in rural communities that will continue to meet the diverse medical needs of rural residents. The short term challenge is to ease the pain and difficulty of this transition by introducing greater flexibility and changes in reimbursement and medical review policies. Only then, can we have confidence that quality and access will be maintained in our rural communities as we move to a new order.

Medical Review in Rural Hospitals

Let us turn now to some of AMPRA's observations about the problems confronting the medical review process in rural areas. AMPRA confines its remarks to the medical review arena given our experience in the field. We recognize, however, that the problems of health care delivery in rural areas are multi-dimensional in nature and must be addressed from various perspectives (i.e. reimbursement, medical personnel, resource capacity, utilization, etc.). The most striking and consistently reported problem identified by our members is the lack of appropriate services outside of the acute care hospital to which patients can be referred for treatment. There are often gaps in the range of resources available in rural communities. These gaps produce pressures to admit some patients to hospitals that are not consistent with the criteria we have developed for determining medical necessity or appropriate level of care.

Current Medicare regulations reserve coverage of inpatient hospitalization for treatment which could not be provided in an alternate facility. Under the federal definition of "medical necessity for hospital admission", only factors directly related to the patient's medical condition and care are to be considered by PROs in their reviews. Social factors such as a patient living alone, living at a distance from the hospital, lacking a social support structure, and requiring custodial level of care, are not to be considered. Similarly, the availability of alternative care at the time the patient requires it cannot be considered.

The Health Care Financing Administration has increasingly pressured PROs to apply these rules stringently. No current DRG classification exists to handle hospitalizations based on these needs. Hospitals will receive a denial of admission necessity for such admissions, possibly resulting in a lack of payment and affecting the hospital's future payment for other cases via the waiver status.

Practicing physicians recognize that the appropriate care of a patient involves consideration of all of the patient's needs, physiologic as well as social and psychologic. Furthermore, practicing physicians face the realities of inadequate community resources and inavailability of alternate facilities on a 24-hour-a-day basis. In the absence of alternative facilities, the caring physician must frequently choose hospital admission for the patient with an acute need for custodial care, for the very anxious or demanding, or for the patient who needs observation in a controlled environment. Physicians who ignore these needs face loss of patient trust and possible litigation.

Consider the case of an elderly woman who comes to the hospital for an ambulatory surgical procedure. Because the patient lives alone, at a distance, and is very anxious about possible complications, her physician arranges for her to stay overnight following the surgery. In the absence of a "medical necessity" for this stay, the PRO must deny the case, the hospital risks nonpayment, and the physician and patient receive letters implying misutilization.

Another example is the unfortunate but common "E.R. dump". What does the caring physician do with the chronically ill and debilitated patient who is left at the E.R. by an unsupportive and demanding family? If there is no need for acute, inpatient level services, this inevitable admission must also be denied for lack of "medical necessity".

In these cases, one sees evidence of a poor "fit" of the Medicare Prospective Payment System to the real world of clinical medicine. Lack of correlation results in considerable antagonism against the Medicare Prospective Payment System on the part of physicians and patients alike. This creates a sense of decreased quality of care and results in attempts to justify patients' admissions on medical grounds which may not be actually present. The physician, whose only choice is between discharging a patient to an inadequate environment or admitting the patient, is tempted to act in the interest of the patient and hospital by ordering more care than may actually be necessary in order to justify the admission on medical grounds. This results in overtreatment of patients and overpayment by Medicare, because such practice is difficult to detect.

The DRG system could provide an accurate reimbursement system for all necessary admission, including those based on the patient's social need for observation in a controlled environment. AMPRA proposes that an additional DRG category be included for "social admissions" and for overnight observation following diagnostic or ambulatory surgery procedures. This DRG would pay a relatively low reimbursement to hospitals, in recognition of the relatively low resource consumption required by such patients.

The adjustment of the Prospective Payment System through the addition of this DRG would avoid the chance that a patient would be refused admission to the hospital and would greatly decrease admissions for inflated medical care. This would acknowledge that holistic care of the patient is a valid concept which would justify coverage by the Medicare program. This would decrease the potential for inappropriate issuance of non-coverage notices by hospitals to patients. This would also increase respect for the Medicare system by physicians, who would perceive that the system recognizes the reality of medical practice, and by patients who would perceive the Medicare system as providing adequate care of appropriate quality.

The budgetary effect overall would likely be money-saving for Medicare and beneficiaries both. The burden of cases which would be paid would be limited by the relatively low cost of the reimbursement. Cost savings to the Medicare program would result from a decrease in the number of cases currently passing through the system with inappropriately high reimbursement weights. Patients' out-of-pocket costs would decrease because there would be fewer non-covered stays, which patients must pay at per diem hospital rates.

The appropriate use of this proposed new DRG would occur for those patients who do not meet the current definition of medical necessity but require admission to the hospital because of social factors. In addition, AMPRA proposes that this "social" DRG be implemented on an interim basis, recognizing that communities over time should be advancing towards a more appropriate mix of community resources. AMPRA believes PROs are in a position to oversee and monitor the use of this DRG after implementation.

In the course of PRO review, AMPRA members have also identified a recent change in the PRO program which we believe may exacerbate the economic pressures on rural hospitals. Under new regulations concerning the application of the waiver of liability published in March, low volume Medicare providers are potentially at much greater risk from PRO payment denials. Earlier policy gave hospitals protection from the financial consequences of PRO denials so long as their denial rates did not exceed 2.5% or 3 cases. The regulations have eliminated this favorable presumptive status and individual hospitals must convince the PRO in each denial that it did not know or could not have known that the services were not medically necessary or appropriate in order to receive Medicare payment for the admission.

In a small rural hospital, the denial of even one or two Medicare admissions could have a substantial impact on the financial condition of the institution. We believe the new waiver policy may be too rigid with respect to rural facilities. AMPRA believes that greater reliance on preadmission certification rather than retrospective review and/or implementation of the aforementioned social DRG would greatly reduce the burden of this new waiver policy.

On a more positive note, AMPRA would like to point out that under the new scope of work proposed by HCFA for the next cycle of PRO contracts, the threshold for triggering intensified review of hospital admissions (100% review) has been raised. The new threshold for intensification is a denial rate of 5% or 6 cases in a quarter in contrast to a denial rate of 2 1/2% or 3 cases in the present scope of work. This change should be important to rural hospitals for whom intensified review is both a burdensome and costly requirement. Just the costs of copying medical records for PROs can place a severe financial burden on rural hospitals. AMPRA predicts that this medical review policy change will result in appreciably fewer rural hospitals on intensified review thus reducing the potential for PRO denials and the administrative costs of complying with PRO review.

Expanded PRO Review

As the changes in the structure of the delivery system take place across the country, we expect that the scope of PRO review activities will necessarily expand. Already there is a new mandate to apply pre-procedure review to a number of ambulatory surgical procedures, a new emphasis on assessing the quality of services provided, and a requirement for the review of services provided by HMOs and competitive medical plans under Medicare at-risk contracts.

As we anticipate the changing locus of care in rural settings, there is every reason to expect that the focus of PRO reviews will also include care given outside the inpatient arena. While the volume of review activities in these rural areas will not be large, it may provide us with more opportunities to experiment with new review methodologies and more focused approaches before applying them to large volume settings.

PROs are increasingly sensitive to the problems and challenges of the rural health providers. Many of our members, in fact, practice in these settings. Within the bounds of our present contracts we are seeking to operate with flexibility and sensitivity. However, we do believe some policy changes are called for, if only on an interim basis. We want to work with these institutions, with their medical staffs and with HCFA to help make the transition in rural health care delivery as smooth as possible. We have not addressed any of the payment policies that could be considered to help rural institutions because they are outside of our purview. Yet, we suspect that modifications in PRO review activities need to be combined with payment policy revisions.

Again, we want to thank you for this opportunity to present our views and recommendations. We would be glad to respond to any questions that you or other members of the Subcommittee may have.

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1) AMPRA's recommendation was based on a legislative proposal developed by David Potash, M.D., former Medical Director of the Washington State PRO.

STATEMENT OF EUGENE C. BECK, DIRECTOR, OFFICE OF RURAL HEALTH, INTERMOUNTAIN HEALTH CARE, INC., SALT LAKE CITY, UT

Mr. BECK. Mr. Chairman and Senator Baucus, it is a thrill for most of us to be able to be here today. It is also an effort, an economic discipline for us to be here. The cost of this hearing would help float a lot of small hospitals for a period of time. That is one of the first points I want to make, is that the cost of solving most of the problems, for this purpose of this hearing are not significant in the overall budget. But, we are not here to plead for something for nothing.

We are here to demonstrate that there is a valid purpose for having rural hospitals. The reason that I specifically was asked to testify today is to describe some of the things that we have been doing as systems in trying to improve the efficiency of rural hospitals. The earlier testimony from HCFA staff, talked about there was room for improvement. I have been involved with trying to improve these hospitals for over 15 years.

I was involved in the first set of hospitals in Swing Beds back in 1973, when the original experiment was authorized in Utah. I have been involved in the early days of home health agencies trying to change inpatient activity over to outpatient, providing operational systems, such as standardizing accounting systems, data processing systems, centralizing cash, using a corporate system to gain access to capital.

In our system we gained access to capital. That has not been an issue for our small hospitals, because they were part of a system that provided that for them. What we have found is that with all of the things we have been doing, I feel just a little bit like Congressman Watkins this morning. I feel like I have been a failure after 15 years, because the things we worked hard for, the things that we tried to be on the cutting edge for, are going down.

And, they are going down very dramatically and I continued to be shocked and appalled that part of the system in Washington feels there is not a problem. There is a problem. Those who take the time and work with us, and we have had a number of them come to Utah and work with us in our system. Ed Mihalski was with us in January of this year as was Bob Helms, Greg Robb was with us a few years ago, Senator Baucus remembers.

And, I think we have been able to demonstrate the things that are going on in those communities are the things that need to be done. We are improving the efficiencies, but we are not able to do it fast enough, when the payment system is changed so dramatically and not put together on an equitable basis for us.

I think that is all I will say at this time and I will be ready for questions.

Senator DURENBERGER. I thank you.

Frank Trembulak.

[The prepared statement of Mr. Beck follows:]

TESTIMONY
OF

EUGENE C. BECK,
VICE PRESIDENT, OFFICE OF RURAL HEALTH
INTERMOUNTAIN HEALTH CARE, INC.
SALT LAKE CITY, UTAH

BEFORE THE SENATE FINANCE COMMITTEE
MAY 9, 1986

I am Eugene C. Beck, Vice President, Office of Rural Health at Intermountain Health Care, Inc. (IHC). IHC is a non-profit health care corporation owning or managing twenty-four hospitals in Utah, Idaho, and Wyoming. IHC also provides a wide variety of non-hospital services (including primary care, home care, and occupational medicine) and operates a health maintenance organization (HMO) and preferred provider organization (PPO). IHC owns a number of large urban and suburban hospitals, including several major referral centers, but the majority of IHC's hospitals are small, rural institutions. Many of those rural hospitals are sole community hospitals under Medicare.

I am responsible for development and implementation of health programs and services in the rural communities served by IHC, consistent with IHC's stated mission and longstanding commitment to high quality rural health care services. In the past fourteen years, I have held a variety of positions related to rural health, including administrator of three rural hospitals (simultaneously) and Regional Administrator and Regional Vice President responsible for eight rural hospitals, thirteen outreach clinics, and related services, including home health. In addition, I am director of a Robert Wood Johnson Foundation project on Hospital Initiatives in Long-Term Care. This four-year project is testing innovative approaches in using hospitals to coordinate health and social services for the elderly in eight communities.

I am grateful for the opportunity to present my views and for the Finance Committee's interest in the future of rural hospitals. As you know, rapid changes in health care finance and delivery have combined with the economic problems facing the agriculture, mining, and energy industries to create an explosive mix, one that jeopardizes the future of many rural hospitals. The purpose of my testimony is to describe briefly some of the steps IHC has taken to cope with these problems.

Before describing those steps, I would like to emphasize that private efforts alone are not enough to assure the stability of our rural health care system. I am proud of IHC's record in improving the efficiency of its rural institutions, and I believe we can, and will, do still more. In the long run, however, we cannot succeed without your help. Flaws in Medicare's prospective payment system have weakened the financial standing of rural hospitals faster and more dramatically than we can improve efficiency.

IHC has employed two strategies for meeting the special needs of rural hospitals; I will call them the "consortium strategy" and the "vertical integration strategy." These expressions do not have fixed meanings, and there is no clear line between them. Often, the consortium strategy will be an initial step in the evolution toward vertical integration.

Under the consortium strategy, which IHC pursued in the years preceding Medicare's prospective payment system, rural hospitals are linked to one another through a variety of agreements. The hospitals participating in a consortium may or may not be jointly owned. (Logan Regional Medical Center, an IHC hospital in northern Utah, is currently in a consortium with several non-IHC hospitals.) The goal of a consortium is to build strength through mutual support. Although a consortium could conceivably include one or more urban hospitals, IHC's consortium in southern Utah included eight rural hospitals.

Membership in a consortium can provide significant advantages to a small hospital. The members can share management, thus cutting overhead. As I said earlier, I served as administrator for three IHC hospitals with a total of 77 beds. Consortium hospitals can also pool their purchasing power through joint purchasing agreements, winning lower prices on many hospital supplies and services. Consortium hospitals can also combine their efforts to recruit physicians.

Recruiting physicians is obviously important. Without physicians, there can be no hospital. One problem is that young physicians, having been trained in the era of high technology, are sometimes reluctant to practice in rural facilities lacking the latest technology and support services. One advantage of membership in a consortium is that member hospitals gain access to jointly owned equipment, for example mobile diagnostic equipment.

The degree to which the members of a consortium are integrated depends on the particular arrangement. In some cases the level of integration can be quite substantial, particularly if the hospitals are under common ownership. In the extreme case, the line between the consortium strategy and the vertical integration strategy can become blurred. I would submit, however, that the distinction never disappears. The key difference between the two strategies is that the vertical integration strategy, by definition, links institutions and facilities of *different* types.

A vertically integrated system, like IHC's, includes large and small hospitals and urban and rural hospitals, as well as a variety of non-hospital services--for example, freestanding primary care clinics and ambulatory surgery facilities, home care, and perhaps most important, an HMO and/or PPO.

IHC is vertically integrating its rural and urban hospitals in both in its northern and central regions. In the northern region, IHC recently purchased the Evanston (Wyoming) Regional Hospital, a 42-bed hospital. Many Evanston residents were travelling to another IHC hospital, the 380-bed McKay-Dee Hospital Center in Ogden, Utah. By purchasing the Evanston hospital, IHC is able to provide more convenient primary care to Evanston residents and to formalize referral patterns to the hospital in Ogden.

The Evanston and McKay-Dee hospitals are linked both clinically and administratively. For example, patients in need of sophisticated diagnostic procedures are referred to McKay-Dee's new magnetic resonance imaging department. Physician, patient, and staff education programs are shared between the two hospitals, and the administrator at Evanston serves as an assistant administrator at McKay-Dee with access to the larger hospital's resources and staff.

In IHC's central region, Utah Valley Regional Medical Center provides blood, radiology, and general lab services to five IHC-owned or leased rural hospitals within a 130 mile radius. All non-emergency lab samples are carried by courier from the rural hospitals to Utah Valley for analysis. The results are then transmitted electronically back to the rural hospitals. Utah Valley also provides inventory and supply services to the same hospitals, as well as carrying out all of the business office functions. As a result, the rural hospitals need only maintain admitting and medical records departments, which permits them to reduce their FTEs up to 10 percent.

Physicians from Utah Valley hold clinics at other hospitals in the region in urology, behavioral medicine, oncology, perinatology, neonatology, arthroscopy, among other disciplines. Physicians practicing in the rural areas, in turn, refer patients to Utah Valley for secondary care. *This is a critical point: the relationship between the rural and urban hospitals is symbiotic, not one-sided.* Vertical integration does not necessarily mean urban hospitals subsidizing rural hospitals, at least not in the long run. To be sure, urban hospitals can help rural hospitals overcome difficult periods (for example, those associated with temporary economic distress in rural communities), but the urban hospitals also stand to gain from the relationship. That is particularly true when urban hospitals are themselves suffering from increased competition and declining occupancy.

Of course, the most important winner from successful integration of urban and rural hospitals is the rural patient. Not only do rural patients benefit from lower costs at their local facilities, they gain access to a health care system providing a range of high quality services in appropriate settings.

Although vertical integration often entails shifting patients from rural to urban hospitals, that is not always the case. We expect IHC's HMO and PPO to increase the number of patients treated in our rural hospitals. For example, Educators' Mutual Insurance Company, which insures Utah's teachers, has agreed to offer IHC's PPO. Since Educators' Mutual does business in every Utah county, the PPO's success will almost certainly mean more patients for some of IHC's small rural hospitals. Although it is rare to find hospitals close to one another in rural Utah, there is long distance competition; some rural patients are willing to travel long distances to obtain high quality care at a lower price. By effectively managing utilization and establishing an economic incentive to go to our hospitals, IHC's PPO will give our hospitals an advantage in that competition.

IHC has tried both the consortium and vertical integration strategies. *For our purposes and in our markets*, we believe vertical integration is the logical step. The consortium strategy simply does not go far enough. The consortium strategy was acceptable in the pre-prospective payment era when the pressure to reduce costs was not as great. In today's environment, IHC believes more complete integration is necessary. For other hospitals, that may not be true.

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The Finance Committee must also remember that many rural hospitals will not have the luxury of vertical integration with an urban system. These hospitals, in particular, will be heavily dependent on your making the proper policy decisions, especially with regard to Medicare's prospective payment system. Even systems like IHC's cannot innovate fast enough to keep pace with growing financial pressures on rural hospitals. As I said at the outset, we have made considerable progress and we can do still more--but our efforts will not suffice. We need your help.

Thank you for the opportunity to present a statement. I would be pleased to answer the Committee's questions.

STATEMENT OF FRANK TREMBULAK, SENIOR VICE PRESIDENT AND TREASURER, GEISINGER FOUNDATION, DANVILLE, PA

Mr. TREMBULAK. Thank you, Mr. Chairman and Senator Baucus. My name is Frank Trembulak and I am senior vice president and treasurer of the Geisinger Foundation.

Senator DURENBERGER. Would you please, Frank, pull your microphone a little closer.

Mr. TREMBULAK. Thank you.

The Geisinger Foundation is pleased to have this opportunity to testify on the issue of rural hospitals under the Medicare Program. Geisinger, a rural health care system, serves approximately 2 million residents within a 20,000 square mile region in Central and north-central Pennsylvania. Our service area is made up of underemployed, low income and aged population.

Geisinger owns and operates two hospitals, an alcohol treatment center, a rural health maintenance organization, and physician practice sites located in 30 communities throughout our rural service area. Additionally, Geisinger has managed several small rural hospitals, nursing homes, rural health clinics, and other types of rural providers.

Geisinger is committed to the development and maintenance of a rural regional health care system that provides care in the rural communities where the people reside. Although Geisinger has experience in all aspects of rural health care delivery, our comments are based on the view of the Geisinger Medical Center, one of the five rural regional referral tertiary care centers with 500 or more beds in the United States, which is Geisinger's flagship facility.

Congress acted responsibly in initiating Medicare reimbursement reform to bring spiraling health care costs under control. However, the financial impact of the legislative and regulatory initiatives that have been implemented are yet to mature, while the administration proposes an ever growing list of added changes.

The turbulent legislative and regulatory payment environment is rife with numerous and frequent changes that are difficult to financially assess. A juggernaut is being created that will dramatically over compensate, forcing the pendulum to swing to far. The resulting damage to the nation's rural health care delivery system will accrue future costs far in excess of short-term savings.

Geisinger Medical Center is noted nationally for its quality clinical program and its progressive management. In spite of these strengths and an ongoing effort to manage health care costs, the medical center was not adequately prepared for the sudden implementation of the prospective payment system. Management embarked on an aggressive development approach to explore ways in which the medical center could continue to enhance its comprehensive clinical, educational, and research programs in a constricting economic environment.

Examples of these management initiatives, which are more fully described in our written testimony are facilities management planning, capital investment analysis, physician management education, and rural community hospital support.

Financially, Geisinger Medical Center must generate certain operating surpluses to create the cash flow necessary for a regional referral tertiary care center. However, the cumulative long-term effect of the payment and other changes being proposed will significantly diminish the medical center's future profitability. The declines are of a magnitude which preclude Geisinger Medical Center from its rural regional referral tertiary care center role.

The PPS Program was introduced to bring the Medicare health care cost component under control. PPS, superimposed on the historical Medicare cost reimbursement principles, promised efficient, and effective providers financial incentives for their performance. However, before the program even matured, significant modifications were being implemented with others under discussion. The compounding effect of the PPS program and the enactment of legislation in the areas outlined in our written testimony indicate that, indeed, the pendulum will swing too far.

Certain examples have been spoken of this morning, such as capital reimbursement, tax-exempt financing constraints, quality of care, required second surgical opinion, and so on. These items do not consider the effects of other operational issues and the hidden problem, which will result by the dramatic increase in health care competition. Financial failures and impairments of quality of care appear to be the obvious future results of this trend.

In conclusion, it is apparent that the nation is not establishing health care policy either on a short-term or long-term basis, but rather allowing the Administration, via the Office of Management and Budget, to arbitrarily reduce costs through the development of far reaching legislation and implementation of unreasonable regulatory payment changes.

If we are to maintain rural regional referral centers as viable regional resources and urban/rural inequities continue, we must incorporate the original PPS 500 or more bed rural referral center exception in all aspects of Medicare legislative and regulatory payment activity.

When Congress considers an institution, such as Geisinger Medical Center, representing high quality care, aggressive operational and finanacial management, operating in a rural environment being so dramatically affected by the long-term cumulative payment direction, one must question what will happen to less successful, managerially weaker rural institutions that also provide a much needed resource to their rural communities. I think we now begin to see the scope of the problem.

Congress must step away from the budgetary fray to develop an appropriate national health care policy as a foundation and guide for fiscal policy.

Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you.

[The prepared statement of Mr. Trembulak follows:]

Statement
of the
Geisinger Foundation
to the
Subcommittee on Health
Committee on Finance
United States Senate

"RURAL HOSPITALS UNDER THE MEDICARE PROGRAM"

Presented by
Frank J. Trembulak
Senior Vice President and Treasurer

May 9, 1986

Mr. Chairman and Members of the Subcommittee:

My name is Frank J. Trembulak, I am Senior Vice President and Treasurer of the Geisinger Foundation. With me is Michael E. Leighow, Administrative Director for Financial Planning and Reimbursement of Geisinger System Services, a Geisinger Foundation affiliate. The Geisinger Foundation is pleased to have this opportunity to testify on the issue of rural hospitals under the Medicare Program.

Geisinger, a rural health care system, serves 2,000,000 residents in a 20,000 square mile region of Central and Northeastern Pennsylvania. Geisinger Medical Center ("GMC"), is one of five rural referral tertiary care centers of 500 beds or more in the United States, is Geisinger's flagship facility on which the majority of our comments are based. (Geisinger's organization and service area are described further in Exhibit I.)

Geisinger's Perspective

Congress acted responsibly in initiating Medicare reimbursement/payment methodology innovations to bring spiraling health care costs under control. However, the financial impact of the legislative and regulatory initiatives that have been implemented are yet to mature while the Administration proposes an ever growing list of added changes. The turbulent legislative and regulatory payment environment is rife with numerous and frequent changes that are difficult to financially assess.

The development, passage and now implementation of the numerous Prospective Payment System ("PPS") revisions resulting from the Omnibus Budget Reconciliation Act (COBRA) typify this problem. A juggernaut is being created that will dramatically over compensate forcing the pendulum to swing too far. The resulting damage to the nation's health care delivery system will accrue future costs far in excess of short-term savings. GMC's experience and projections of PPS and related legislative and regulatory proposals set forth herein support this perspective.

GMC Responds to the Implementation and Impacts of PPS

GMC has always prided itself on not only its clinical programs but also on quality management in being able to package and provide sophisticated tertiary care in the most cost effective manner. In spite of a progressive management style and an ongoing effort to manage health care costs, the medical center was not adequately prepared for the sudden implementation of the PPS. Facing reduced payments for services, lack of appropriate resource and utilization information, and relatively short lead time to respond, management embarked on an aggressive development approach to explore ways in which the medical center could continue to enhance its comprehensive clinical programs in a constricting economic environment. At the same time we decided to address the challenges PPS posed to our mission of patient care, education and research, we agreed not to be drawn reactively to diversification. A brief overview of some of these management initiatives follows:

Productivity Management

Historically, GMC has been actively involved in developing management tools to monitor resource utilization. In 1980, a Nursing Management Reporting System ("NMRS") was installed to determine nurse staffing requirements based on patient severity of illness measurements. In 1984, the system was enhanced to evaluate nurse staffing and scheduling requirements on a shift-by-shift basis to achieve maximum personnel utilization. As the initial impact of PPS began to decrease inpatient utilization, a 10% decrease in nurse staffing requirements was identified and staff reductions resulted. The NMRS has enabled management to identify and address $2.5 million in labor savings during its five year use.

Manpower productivity is currently monitored for 30% of GMC's work force with departmental reviews underway to increase this monitoring level to 70% by the end of fiscal year 1987. The Productivity Management Reporting System ("PMRS") is being linked to comprehensive cost accounting and case mix systems also under development to enable the medical center to establish standard costs for both labor and non-labor components of all major services.

Manpower Planning

The medical center has implemented a zero based budgeting approach for all new and replacement manpower requests which must be justified to a senior management level Manpower Planning Committee. The Committee reviews every position request and challenges departmental management to seek operating methods in lieu of adding manpower costs to address their needs. Over the past 18 months this program has reduced the full-time equivalent staffing by approximately 165 positions.

Business Planning

GMC has expanded the traditional approach to capital and operating expense budgeting to include a comprehensive business planning process. This program incorporates a detailed analysis of functional management issues, identifies changes in product lines and market demands, details new program development, explores the down sizing and potential elimination of current programs, and identifies major reimbursement and payment issues with recommended operational approaches.

Facilities Management and Planning

Our continuing concern with increasing new and replacement construction costs, compounded by the tertiary care nature of the medical center, moved us in 1976 to develop an internal facilities management capability. This program has grown and now provides professional facilities management planning, registered architectural and construction management expertise which has contributed an estimated savings ranging from 10% to 25% on our capital expenditures for new, replacement and renovated facilities. In addition, the facilities planning process is being incorporated into the overall medical center business plan to better coordinate and manage these vital resources. Methodology is being developed to define facility utilization as a tool for senior management to evaluate any capital expenditure for major renovation or new construction. This process includes a facilities information data base, which identifies both under and over utilized space.

Capital Investment Analysis

In addition to the aforementioned facilities planning activity, projects requiring significant capital investment must be justified through an extensive quantitative evaluation of each proposal. To support this effort, Geisinger has developed and implemented a discounted cash flow model to evaluate the feasibility of large capital expenditures. This model addresses operational impacts and costs, as well as opportunity costs, equipment capacity planning, labor productivity and several other factors affecting the investment decision.

Physician Management Education

In the rapidly changing health care environment, GMC recognizes and supports the importance of involving physicians in management. To this end, the medical center conducts programs for medical staff division chairmen, clinical directors and other physicians who have specific management responsibilities. In addition, the Geisinger Clinic, in cooperation with Susquehanna University in nearby Selinsgrove, Pennsylvania, offers a physician management educational program for the development of the professional physician manager. This program has been partially funded by the Robert Wood Johnson Foundation.

Community Hospital Support

GMC offers clinical and management support to the community hospitals in the region. These efforts support and enhance the regional health care system. This informal network has developed well on an as-needed basis.

Financial Management Concepts

GMC practices and strongly supports sound financial management concepts in the not-for-profit health care sector. For any economic unit to succeed in carrying out its mission and to grow, it must generate an adequate operating profit to provide the cash flow necessary to meet its capital requirements. GMC, to fulfill its operational scope and role as a rural referral tertiary care center, works to achieve a 6.0% net operating return on its total net income. This level of profitability provides for necessary working capital requirements.

- Covers operating expenses during the time lag between the provision of services and the collection of charges;
- Enables the maintenance and/or building of inventories;
- Allows for the increase in insurance premiums on prepaid insurance; and,
- Enables the payment of debt service particularly when annual principal payments exceed asset depreciation.

- Permits the establishment of reserves as contingencies for funding unanticipated difficulties caused by such things as extraordinary losses on assets, or increases in such costs as insurance premiums.
- Provides funds for uncompensated care.
- Enables the development and maintenance of quality educational and research programs.

In addition, cash flows must be accumulated for sound capital asset management; i.e. major renovations and repair, replacement of plant and equipment, expansion and new technology. Further, without three essential elements -- adequate profitability, cash flow and accumulated reserves -- the medical center's access to external capital would be greatly reduced by poor credit ratings and the resulting increase in capital costs.

Management initiatives as those reviewed enabled GMC to maintain profitability during its first two years under the PPS, although not consistently achieving the 6% financial goal noted above. (See Table I). However, the cumulative long-term effect of the payment changes being proposed will significantly diminish the medical center's future profitability.

Concerns - "The Pendulum May Swing Too Far"

Subsequent to World War II, major national health care policy dealt with access. Various programs were established, over time, to encourage facility growth, technology development, physician training and payment mechanisms for the elderly and indigent. All these activities were well intentioned and addressed current problems but led to significant industry growth accompanied by ever rising costs. Inevitably, health care industry costs became financially unacceptable on a national level. The pendulum had swung too far.

The PPS program was introduced to bring the Medicare health care cost component under control. The PPS, superimposed on the historical Medicare cost reimbursement principles, promised efficient and effective providers financial incentives for their performance. However, before the program even matured, significant modifications were being implemented with others under discussion. The compounding effect of PPS and the enactment of the following items indicate that the pendulum will again swing too far.

Capital Reimbursement

Numerous proposals have been sought to address the reimbursement of capital costs, moving from a pass-through methodology to an amount to be included in the Diagnostic Related Group ("DRG") payments. Although we agree with the necessity to bring capital payment into the DRG payment scheme, an accelerated conversion/implementation will result in significant financial hardship and possible legal default on current outstanding debt obligations by many hospital providers. Those institutions with new facilities will be penalized while those with old and perhaps antiquated facilities will reap significant windfalls.

The methodology selected must provide either prior capital grandfathering and/or allow for a significant conversion period to give the industry necessary time to plan for and respond to the change. Senator Durenberger's capital payment proposal appears the most realistic. However, a seven year phase-in will not allow providers to financially or legally address their current position. As Congress reviews the capital issue the Administration continues to pursue an unrealistic four year phase-in approach. Actions should be taken to block this proposal until all facts are carefully studied and an informed decision made.

In addition, GMC as a rural referral center can demonstrate the lack of clear distinction between rural and urban capital costs.

- Sophisticated technology is purchased from the same vendors at the same prices. However, maintenance may cost more in the rural verses urban setting due to rural distances and lack of a field support network.
- Specially trained personnel to operate sophisticated technology generally command a salary based on national markets.
- Architectural and engineering capabilities necessary for major construction programs are not available in rural areas and must be obtained from urban areas.
- Major building products and systems are not generally available in rural areas. They must be acquired in the metropolitan area and transported at significant cost to the rural job site.
- Construction wage rates may vary but on major projects even rural providers use union labor thereby minimizing such differences.

Therefore, such consideration is not justified, particularly for a rural referral tertiary center of 500 beds or more.

Uncompensated Care

Uncompensated care represents medical services to patients who are unable to pay for their care and have inadequate insurance. Hospitals serving a disproportionate share of indigent patients require enhanced payments to continue to provide uncompensated care which should be funded in part by the Medicare Program. Uncompensated care represents a national problem requiring payment policy development at the national level. Adequate financial consideration must be given to tertiary care referral centers acting as providers of last resort. Their unique role should not harm them financially. In contrast to the Health Care Financing Administration's ("HCFA") definitions of disproportionate share facilities, GMC supports the subject definitions in COBRA. However, the medical center strongly urges that you clarify that the urban disproportionate share definition be applied to 500 bed or more rural referral tertiary care centers. Not doing so unfairly penalizes those organizations who provide services on a similar scope and patient mix as their urban counterparts.

Tax-Exempt Financing

The decline of philanthropy and government grant programs, combined with an increase in pressure on operating margins, has made tax-exempt financing the most cost effective source of capital for the not-for-profit health care sector. The financial impact and instability created by PPS has resulted in an adverse affect on the not-for-profit hospital's access to the capital markets by raising serious concern over the financial viability of not-for-profit hospitals under such payment programs. The need for capital over the next decade is one of the most crucial issues facing our nation's not-for-profit hospitals. It is imperative that our health care delivery system be able to replace, modernize and renovate its primary resources, comply with life safety and other code changes, acquire sophisticated medical equipment and retain the ability to restructure debt obligations through the tax-exempt market. To elimininate or cap tax-exempt financing for not-for-profit hospitals, in light of the previously mentioned PPS pressures, would deny access to capital markets for a majority of institutions beyond those already facing difficulties from the PPS transition. Paradoxically, such tax reform would significantly raise capital costs for hospital replacement and renovation for those institutions still able to gain access to capital markets in a time when the nation is concerned with the increases in health care costs.

Geisinger strongly advocates retaining the tax-exempt financing vehicle for the not-for-profit hospital sector. Over time, continuing declines in operating profitability will, through attrition, greatly reduce the volume of tax-exempt transactions.

Quality of Care

Quality assurance and peer review programs are an essential part of maintaining a quality health care system. Adequate quality control must continue in light of inherent PPS incentives to reduce costs which may in turn affect quality. Any federally mandated quality assurance programs should be carefully scrutinized by HCFA to avoid duplicative and costly provider reporting requirements. New program initiatives must be carefully structured to avoid costly compliance criteria when provider payments are being reduced or frozen.

GMC has taken an active role to ensure its continuing level of quality for all patients served. Within the last year, it has implemented the "Caring Program" which, among other things, involves contacting every Medicare patient after discharge. This follow-up assures that any post-hospital arrangements have been fulfilled, any recuperative period is progressing on course, and any abnormalities in the patient's experience are addressed promptly.

Another issue relating to quality and access to care is the growing beneficiary concern with rising Medicare deductibles. The rural elderly find this financial burden an impediment to necessary elective care.

Graduate and Allied Medical Education Costs

GMC currently supports fourteen residency and five fellowship graduate medical education programs including 190 residents and fellows. We also offer nursing school and training programs for nurse anesthetists, radiographic, nuclear medicine and radiation medicine technologists, and medical technology and histology technologists serving over 250 students. The medical center has graduated over 3,500 nursing, radiology, medical technology, nurse anesthesia and pastoral care students and more than 1,700 residents from teaching programs since their inception. The medical center is a net provider of trained health care professionals. Its $11.0 million in educational costs are a significant yet vital part of its role as a rural referral center in that 60% of all of the graduating allied health personnel are employed within the medical center's traditional 30 county service area. The total elimination of Medicare funding for direct medical education costs as sought by HCFA would severely restrict access to quality educational programs serving rural communities.

Medicare should continue to pay for the direct costs of all educational programs on a reasonable basis. To arbitrarily eliminate support by HCFA regulation, would be extremely damaging. In addition, indirect medical education reimbursement, currently excluded from PPS, representing increased patient care costs associated with teaching programs, is also essential to protect adequate long-term health care manpower supplies. GMC has acknowledged its role in contributing private support for these activities but also encourages the Medicare Program to maintain reasonable reimbursement for such important educational activities.

Research Funding

GMC supports a coordinated program of patient care, clinical research and basic research in a continuing effort to expand the medical knowledge base. Continued federal funding of research programs is important to maintain the quality of the health care system and promote development of new, cost effective technologies. The federal government should bear its fair share of research costs. Geisinger is embarking on a significant expansion of its research commitment, focusing on private initiative through private philanthropy. Our goal is 70% of all research funding from the private sector. Geisinger endorses the concept of a public and private partnership in the pursuit of research knowledge. Reasonable caps for reimbursement of indirect administrative pools are supportable. Any caps should be phased in over a reasonable time and should consider the significant indirect costs of starting new research centers.

Tax Reform Impact on Pension Costs

Proposed reductions in annual tax sheltered pension contributions and more stringent discriminatory regulations would place a considerable burden on the not-for-profit sector in recruiting and retaining skilled professionals. The not-for-profits are now prohibited from providing bonuses, stock option and other incentives as their for-profit counterparts. These regulatory changes will require the not-for-profit providers to incur additional costs to compensate for this shift in administrative direction.

Congress and the Administration have been encouraging the private development of pension benefits. These proposed changes will significantly impair any such initiative.

Deficit Reduction Act - 1984 - Lower of Cost or Charge Rules Application

The Medicare application of the lower of cost or charge rules are now only being applied to hospital outpatient activities since inpatient costs were incorporated under PPS. This change significantly affects rural referral centers promoting and conducting significant ambulatory care programs.

This difficulty is magnified when certain outpatient services are carved out of the methodology for various reasons and physicians, providing services in the medical center's ambulatory care facility, are subject to Section 104 of the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") which limits payments for office visits to 60% of the nonspecialist Medicare allowable charge regardless of the Geisinger specialist involved. We question HCFA's regulatory implementation of these items. We believe HCFA is in nonconformance with the original congressional intent and find significant inequities in the current application of these regulations. Congress should repeal Section 2308 of the Deficit Reduction Act of 1984 and instruct HCFA to utilize specialist profile comparisons as appropriate when developing the modified outpatient hospital physican payments.

COBRA - Required Second Surgical Opinion

The Medicare beneficiary in our rural region travels an average of 50 or more miles for GMC's tertiary capabilities provided by its group practice model of full time salaried medical staff. Under the subject legislation, the beneficiary must now endure more travel in attempting to locate physicians qualified to provide the second opinion.

GMC strongly urges Congress to extend the original PPS 500 beds or more rural referral center exception to this burdensome legislative requirement.

Other Operating Issues

In addition to the legislative and regulatory items mentioned, there are other significant operating concerns with which the industry is coping. For example, the insurance liability crisis is escalating insurance premiums at both an unrealistic and totally unacceptable rate and forcing many providers to operate with reduced or inadequate insurance protection.

Another element weighing heavily in the current environment is the dramatic increase in health care competition. The competitive trend is enhanced by the blurring of traditional roles as providers now become insurers, insurers become providers, and payers become both insurers and providers. Financial failures and impairments of quality of care appear to be obvious future results of this trend.

Projected Financial Impacts of the Prospective Payment System and Related Legislative and Regulatory Proposals

GMC, as part of its business planning process has worked to quantify and project its current operating performance as it will be affected by both the implemented and proposed legislative and regulatory issues. The results are disastrous and can be noted on Table I and supplemental statistical Table II and assumptions on Table III.

Table I

Geisinger Medical Center

Statement of Revenues and Expenses

For the Years Ending June 30,

(thousands of dollars)

	Actual	Year to Date March 31,	Anticipated Final	Business Plans			
	1985	1986	1986*	1987	1988	1989	1990
Gross Revenue	$ 158,733	$ 128,034	$ 169,359	$ 175,040	$ 183,901	$ 195,697	$ 208,664
Less Deductions from Revenue	31,486	26,876	29,499	34,655	42,270	50,534	58,363
Net Revenue	127,247	101,158	139,860	140,385	141,631	145,163	150,301
Operating Expenses	121,664	94,136	125,181	132,933	138,228	144,218	150,020
Excess Operating Revenue Over (Under) Expenses	5,583	7,022	14,679	7,452	3,403	945	281
Non-Operating Revenue	1,706	2,126	2,787	2,751	2,890	3,030	2,587
Excess Revenue Over (Under) Expenses Before Extraordinary Item	7,289	9,148	17,466	10,203	6,293	3,975	2,968
Extraordinary Gain (Loss) on Bond Defeasance, Net	0	0	0	0	0	0	0
Excess Revenues Over (Under) Expenses	$ 7,289	$ 9,148	$ 17,466	$ 10,203	$ 6,293	$ 3,975	$ 2,968
Percentage of Operating Return	4.39%	6.94%	10.49%	5.31%	2.40%	.65%	.19%
Capital Additions and Replacements	$ 7,322	$ 5,144	$ 5,200	$ 10,450	$ 9,500	$ 7,000	$ 18,000

* Anticipated final includes $5.0 million in prior period Medicare cost settlements and a $1.3 million positive adjustment for the wage index resolution in COBRA.

Table II

Geisinger Medical Center

Selected Statistics

For the Years Ending June 30,

	Actual	Year to Date March 31,	Anticipated Final	Business Plans			
	1985	1986	1986	1987	1988	1989	1990
Patient Days (a)	147,234	111,779	147,814	150,960	148,842	150,775	153,792
Discharges	19,990	14,704	19,578	20,128	20,530	20,941	21,360
Length of Stay	7.37	7.60	7.55	7.50	7.25	7.20	7.20
Outpatient Visits	379,004	290,435	387,353	394,945	402,844	410,901	419,119
Medicare Patient Days	51,577 (b)(d)	38,500	52,322 (d)	52,200 (d)	51,475 (d)	51,480 (d)	52,200 (d)
Medicare Discharges	7,082 (c)(d)	N/A	6,930 (d)	6,960 (d)	7,100 (d)	7,150 (d)	7,250 (d)
Medicare Length of Stay	7.28 (e)	N/A	7.55 (d)	7.50 (e)	7.25 (e)	7.20 (e)	7.20 (e)

(a) Includes newborn
(b) Excludes distinct part days of 7,591
(c) Excludes 415 distinct part discharges which count as two discharges when the patient is admitted and subsequently transferred. Distinct part average length of stay = 18.29 days
(d) Represents cases paid under prospective payment system
(e) Reduction reflects impact of excluding distinct part psychiatric and rehabilitation units

Table III

Major Financial Assumptions

Statistics

Inpatient admissions and discharges reflect an annual 2% growth rate with length of stay dropping from 7.50 days to 7.20 days from 1987 through 1990. Naturally, this type of growth in inpatient volume is aggressive. Outpatient visits reflect an annual 2% growth rate with about 395,000 visits projected for 1987.

Revenues

Patient service revenues are consistent with projected volume increases plus assumed fee increases of 5% for each year 1988, 1989 and 1990. The tactic of increasing fees does not appear realistic in view of today's environment.

Expenses

Salary and wages reflect various annual year end adjustments moving to a methodology of lump sum payments to minimize the compounding effect of annual pay increases. No growth in full-time equivalents is projected over the pro forma period. Benefit costs generally follow staffing level growth with an annual 5% inflation factor. All other expenses reflect a 5% inflation rate adjusted for volume increases and specific inflation adjustments for certain expense classifications that are expected to exceed the 5% inflation factor.

Reimbursement

Cost reimbursement for Blue Cross participation is assumed to continue with declining utilization.

Medical Assistance per case reimbursement is assumed to remain flat with no case mix or inflation increases.

Medicare assumptions reflect the following: discharges increase from 6,960 in 1987 to 7,250 by 1990; the case mix index is projected to increase due to more intensive inpatient cases from 1.33 in 1987 to 1.35 by 1990; COBRA provisions relating to prospective payment transition, rate blending, rate increases, direct medical education limits, curvilinear indirect medical education payment formula and nonretroactivity of the revised wage index are included; Gramm-Rudman 1% payment reductions are assumed to continue through September 30, 1986 with no further reductions projected after October 1, 1986 under the assumption that any reductions will be offset by prospective payment rate adjustments; and capital cost reimbursement is assumed to be phased into the DRG payments over a four year period reflecting a 7% capital add on to the per case payment rate.

It is obvious from the foregoing projections that GMC will not be able to sustain its legitimate role as a regional referral center with such significant declines in profitability and diminished cash flow which in turn will bring into play other compounding factors such as the inability to meet debt service obligations and, therefore, default under any outstanding debt.

Conclusions

Geisinger sees the current health care industry as being in a tremendous state of flux moving into a period of significant consolidation and reform. It is apparent that the nation is not establishing health care policy either on a short-term or long-term basis but rather allowing the Administration, via the Office of Management and Budget, to arbitrarily reduce costs through the development of far-reaching legislation and the implementation of unreasonable regulatory payment changes. The industry cannot manage a response when the direction being forced upon it changes too frequently.

GMC, a rural referral tertiary care center with over 500 beds, will be unduly harmed by the accumulated effects of the PPS program and current legislative and regulatory issues. If we are to maintain rural referral centers as viable regional resources, we must incorporate the original PPS 500 beds or more rural referral center exception in all aspects of Medicare legislative and regulatory payment activity.

When Congress considers an institution such as GMC, representing high quality tertiary care, aggressive operational and financial management, operating in a rural environment, being so dramatically affected by the long-term cumulative payment direction, one must question what happens to the less successful, managerially weaker rural institutions that also provide a much needed resource to their communities. Now you begin to see the scope of the problem.

It is imperative that Congress step back from the budgetary fray and develop appropriate national health care policy as a foundation and guide for fiscal policy. Leadership from Congress should give appropriate consideration to dealing uniformly and fairly with the national health care system encompassing such organizations as Geisinger and GMC as a rural referral tertiary care center of over 500 beds. We are positioned proactively to provide quality care at an affordable cost and can work to couple the public and private sectors to effectively address our health care needs and issues.

I will be pleased to respond to any questions the Committee may have.

EXHIBIT I

Geisinger - A Rural Regional Health Care System

The Geisinger health care system had its beginnings in the Northcentral Pennsylvania community of Danville, a town of 5,500, located approximately 75 miles North and East of Harrisburg on the North branch of the Susquehanna River.

Geisinger has expanded dramatically out of the Geisinger Medical Center to better serve its rural service area. However, Geisinger's flagship remains the Geisinger Medical Center, founded in Danville in 1915 by the philanthropy of an 85 year old widow, Mrs. Abigail Geisinger, in memorial to her husband, George F. Geisinger.

Mrs. Geisinger carefully selected the man she would make responsible for administering her hospital; she retained Dr. Harold Foss, an able young surgeon who at the time was first assistant to Dr. William J. Mayo of the Mayo Clinic.

The two years Dr. Foss had spent at the Mayo Clinic significantly influenced his thinking about appropriate methods for delivering health care. From the beginning, Geisinger Medical Center was designed to be a center for comprehensive quality health care serving a wide area of Pennsylvania.

Geisinger's rural health care experience has evolved over a 70 year existence in the Central and Northeastern Pennsylvania region and reflects a hard earned reputation for its comprehensive program of quality care based on a group practice model of medicine combining effective and efficient physician and professional management skills. In meeting the challenge of Pennsylvania's geography, Geisinger has developed a blend of affiliated hospitals, medical group practices, managed hospitals, outreach clinics and chemical and substance abuse centers that are well positioned to serve the health care needs of the widely disbursed rural population.

Geisinger's corporate restructuring in 1981 formed the basis for today's health care system which is made-up of the following affiliated organizations:

- Geisinger Foundation, a not-for-profit corporation, the parent company containing the external Board of Directors;
- Geisinger Clinic, a not-for-profit corporation employing more than 345 full-time salaried physicians responsible for Geisinger's clinical, educational and research programs;
- Geisinger Wyoming Valley Medical Center, a not-for-profit corporation operating an open medical staff, 230-bed community hospital 60 miles Northeast of Danville near Wilkes-Barre, Pennsylvania;
- Geisinger Health Plan, a not-for-profit corporation operating a health maintenance organization currently made-up of 27,000 members which was founded in 1972 and expanded in 1985, and was one of the nation's first rural health maintenance organizations;
- Marworth, a not-for-profit corporation operating a 72 bed alcohol treatment and rehabilitation center near Scranton, Pennsylvania, and a 56 bed adolescent chemical treatment center currently under construction near the Delaware Water Gap;

- Geisinger Medical Management Corporation, a for-profit business corporation that provides management and health care consulting services throughout Geisinger's traditional service area;

- Geisinger System Services, a not-for-profit corporation that provides management and consultative skills to support the other Geisinger affiliates;

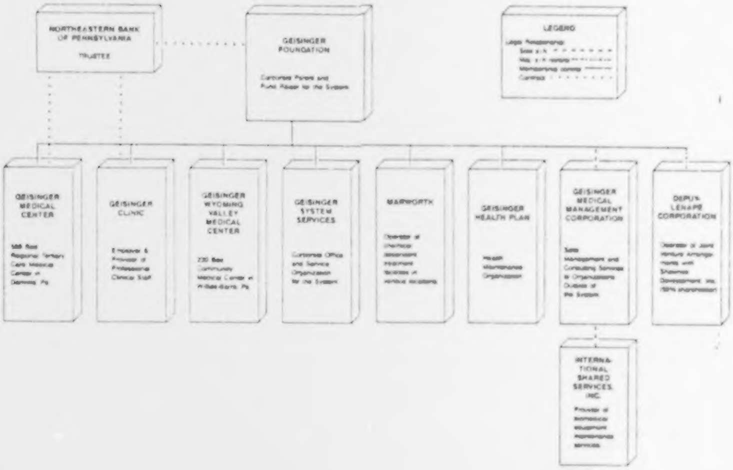
- International Shared Services, Inc., a for-profit corporation operating a biomedical technology engineering service in seven eastern states and the District of Columbia;

- DePuy-Lenape, a for-profit corporation which owns the real estate of one of Geisinger Clinic's outreach locations; and,

- Geisinger Medical Center, a not-for-profit corporation which operates the largest of five rural referral centers in the United States that have 500 or more beds.

Table I

THE GEISINGER SYSTEM


NORTHEASTERN BANK OF PENNSYLVANIA
TRUSTEE
GEISINGER FOUNDATION
Corporate Parent and Fund Raiser for the System
LEGEND
GEISINGER MEDICAL CENTER
500 Bed Regional Tertiary Care Medical Center in Danville, Pa
GEISINGER CLINIC
Employer & Provider of Professional Clinical Staff
GEISINGER WYOMING VALLEY MEDICAL CENTER
230 Bed Community Medical Center in Wilkes-Barre, Pa
GEISINGER SYSTEM SERVICES
Corporate Office and Service Organization for the System
MARWORTH
GEISINGER HEALTH PLAN
Health Maintenance Organization
GEISINGER MEDICAL MANAGEMENT CORPORATION
Sells Management and Consulting Services to Organizations Outside of the System
DEPUY-LENAPE CORPORATION
INTERNATIONAL SHARED SERVICES, INC.

Over the years, the primary purpose of Mrs. Geisinger's hospital, and now the Geisinger health care system, has remained unchanged. That purpose is threefold: clinical care, education and research all dedicated to the well-being of the people of Central and Northeastern Pennsylvania. Geisinger Medical Center's growth and unique demographic characteristics of the region have led Pennsylvanians to depend on our comprehensive regional referral tertiary care services. Because of Geisinger Medical Center, Danville, the nineteenth century milltown of tree-lined curbs and square-roofed houses, has the highest per capita concentration of physicians in the United States. From the medical center, Geisinger's

Life Flight Helicopter airlifts Emergency Medicine teams an average of over three times each day to critically ill and injured patients throughout Geisinger's traditional 30 county service area and beyond.

Geisinger Medical Center and Geisinger Clinic support more than 200 ongoing research projects and the Geisinger system has begun a major expansion into basic medical research. Geisinger has an abiding interest in preventative medicine, education and ambulatory care. In fiscal year 1985, Geisinger Clinic physicians in Danville and at three satellite clinics saw in excess of 564,000 patient visits making Geisinger the largest provider of ambulatory care in the Commonwealth. The Health Maintenance Organization is licensed by the Commonwealth to provide coverage in 17 counties.

The Geisinger Medical Center's medical staff is comprised of 230 full-time salaried Geisinger Clinic physicians practicing in 59 specialties. In addition, approximately 190 graduate resident physicians are enrolled in 14 training programs sponsored by the medical center. Since 1915, Geisinger Medical Center has graduated more than 1,700 physicians and over 2,600 nurses. In 1973, the medical center became a major teaching affiliate of the Pennsylvania State University College of Medicine at Milton S. Hershey Medical Center. Geisinger Medical Center's eleven schools -- among them medical technology, radiologic technology, nursing and nurse anesthesiology -- have graduated hundreds of students.

Geisinger Medical Center employs about 3,100 persons making it one of the largest single site employers in the Commonwealth. Geisinger and the Geisinger Medical Center are involved in many communities, government activities and a variety of social agencies and civic programs. Geisinger is and has always been a constructive participant in efforts to reduce health care costs. Geisinger, specializing in treating the sickest of the sick (60% of all admissions are emergency), can comparably demonstrate the provision of excellence in health care delivered on a cost efficient and effective basis.

Geisinger's Service Area Demographics

Geisinger's current service area corresponds to GMC's traditional service area from the medical center's inception over 70 years ago. The service area spans 30 counties in Central and Northeastern Pennsylvania, ranging over 20,000 square miles with an estimated population slightly in excess of 2,000,000. The region is essentially small towns, rolling farmlands and coal mining areas, punctuated occasionally by medium-sized cities. Only modest population growth is expected over the next five years with most of this increase attributable to the 65 and older age group.

Table II

Population Trends

Age Group	1985 Estimate	1990 Estimate	Percent Change
0-17	515,000	496,300	(3.6%)
18-34	571,500	570,000	(0.3%)
35-64	676,000	687,700	1.7%
65+	327,000	349,100	6.8%
Total	2,089,500	2,103,100	0.7%

In addition to the region's aging population, it is both underemployed and with low incomes as compared to the other counties and the state in general.

Table III

Unemployment Statistics

Description	Calendar Year 1985
30 County Service Area	10.1%
Other 37 Counties	7.5%
Commonwealth of Pennsylvania	8.0%

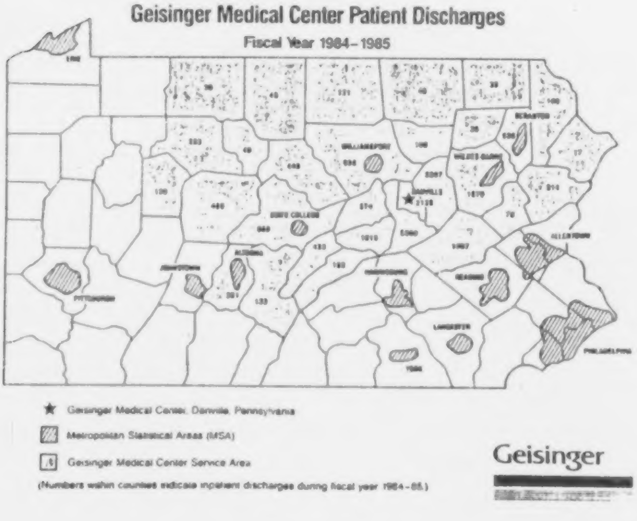
Table IV

Average Household Income

Description	1985 Estimate
30 County Service Area	$ 20,700
Other 37 Counties	$ 26,700
Commonwealth of Pennsylvania	$ 25,600

Geisinger Medical Center experienced admissions from 61 of the 67 counties in Pennsylvania during fiscal year 1985. More than 25% of Geisinger Medical Center's annual admissions for tertiary services come from beyond a one hour driving time.

Table V


Geisinger Medical Center Patient Discharges
Fiscal Year 1984–1985
WILLIAMSPORT
SCRANTON
WILKES-BARRE
DANVILLE
STATE COLLEGE
ALTOONA
JOHNSTOWN
PITTSBURGH
HARRISBURG
READING
ALLENTOWN
LANCASTER
YORK
PHILADELPHIA
★ Geisinger Medical Center, Danville, Pennsylvania
▨ Metropolitan Statistical Areas (MSA)
Geisinger Medical Center Service Area
(Numbers within counties indicate inpatient discharges during fiscal year 1984–85.)
Geisinger

During a public review of a major facility expansion plan in 1978, the Pennsylvania Secretary of Health conditioned his approval of the medical center's program with a challenge to actively pursue the development of a regional system of quality health care. In addition, the Secretary designated GMC as one of four locations where Pennsylvania residents could obtain sophisticated tertiary care services. GMC is the only rural referral tertiary care provider recognized in that designation as the medical center is not located in a Metropolitan Statistical Area.

STATEMENT OF CAROL KIECKER, REGIONAL VICE PRESIDENT, HEALTH CENTRAL SYSTEM, MINNEAPOLIS, MN

Ms. KIECKER. Thank you. I am a regional Vice President of the Health Central System, which is a Minneapolis based multihospital system, that owns and manages 22 hospitals. All, but two of which are in nonmetro areas.

As you know, and has been said earlier today, there are many forces that have lowered inpatient acute utilization in hospitals. And certainly, they were not all caused by the PPS, but the whole thinking has changed. New styles of practicing with less hospitalization. The effect of HMO's, which of course is particularly profound in Minnesota.

Utilization review activity, which almost all peers are using and PRO activities. This has caused us in rural health care a huge change, which we are attempting to respond to. Just, to reiterate and amplify it of course, the reason that this has made such an impact on rural hospitals as compared with urban is because most of the medical staffs of rural hospitals are general and family practitioners and the kinds of cases that they hospitalize are the ones that are no longer hospitalized. For example, pneumonia cases a few years ago, all used to go into the hospital and now they do not. Whereas the specialists still are hospitalizing many of their patients. Neurosurgery patients still go in the hospital in the urban areas.

I only mention that which is obvious, I know, to really give you the feel of what that means to a small rural hospital.

I propose, as others have, that we go to one rate with no differential between urban and rural. I would comment to the HCFA representatives about this wonderful windfall that this will cause. I am not sure at all that it will be a windfall, because we are talking about 1982, 1983, and 1984 data. And, we were doing real well, too, in 1982. A hospital with which I am associated had an average daily census of 42 patients that year. This year we are running 19 patients. So, there has been such a huge change. The data, naturally is lagging and is not keeping up with the information that we really need to know about to make that decision.

A number of reasons for proposing going to one rate are that, while there are some area wage differences, I think they are more than offset by the economies of scale that we lack, which has been mentioned earlier.

Also, I know of no other federally funded program that works this way. If you receive Social Security checks for example, I do not think it is predicated on geography.

Also, since the PPS system was originally designed to save money, I think that you ought to keep the rural hospitals. I think we all agree that they have a lower cost per admission and that certainly would not be the first ones that we would want to get rid of.

The ProPAC committee has testified that even after accounting for the area wage differences, the lower intensity of services and the medical education requirements, the rural rate is still lower than the urban.

So, we are asking rural hospitals to provide things that they can not provide. I mean like blood out of a turnip.

Since economic conditions in rural areas, based on agriculture and mining industries are worsening daily, it does not seem to make good public policy to excerbate that situation, a point that already been made many times today, but I will make it again.

Hospitals will be driven out of business in the rural areas by these policies if there is not some correction made and I think that everyone seems to agree on that today.

Of course, there has been a lot of mention that there are more elderly in the rural areas. Not only is that true, but the elderly people generally get their care in the local community, where perhaps as was mentioned earlier, some younger people leave the rural communities to get their health care services.

I would be willing to maintain budget neutrality on this, since the large perponderance of revenue goes to the urban centers, they would not have to drop very much to have the rural come up to it. Just based on admissions alone, there is about a 4 to 1 ratio, that is, the urbans would have to drop about $1 for the rurals to come up $4 to meet. But, over and above that there is even the weighting of the case mix index, which makes a further impact on that. So, I think that the urbans would not have to drop that much to have the rurals come up to it. And, I propose that is what we do.

[The prepared statement of Ms. Kiecker follows:]

THE
HEALTH
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CORPORATION

THE HEALTH CENTRAL SYSTEM
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STATEMENT OF CAROL J. KIECKER, REGIONAL VICE PRESIDENT HEALTH CENTRAL SYSTEM, MINNEAPOLIS, MINNESOTA BEFORE THE SUBCOMMITTEE ON HEALTH; RURAL HOSPITALS UNDER THE MEDICARE PROGRAM

May 9, 1986

Mr. Chairman, I am Carol J. Kiecker, a regional vice president for the Health Central System, which is based in Minneapolis, Minnesota. Our system owns and manages 22 hospitals in the Upper Midwest, of which all but two are in the non-metro areas. I thank the subcommittee for this opportunity to discuss the situation of these rural hospitals and how the prospective payment system for Medicare is impacting them.

Forces other than the PPS system are causing lower utilization and less revenue for the small rural hospitals. These forces revolve around new styles of practicing (less hospitalization), the affect of the HMOs (especially strong in Minnesota), the utilization review activities that almost all payers are now using, and the PRO activities. There is no question this is a huge change for all hospitals, rural and urban, and we are doing our best to respond to these changes while still preserving the rural health care system.

The reason that these changes have a larger impact on the rural hospitals than the urban hospitals is because most of the physicians on the rural hospital medical staffs are family practitioners and general practitioners. The kinds of cases these physicians hospitalize have seen the greatest change in utilization compared to the secondary and tertiary specialists' cases. For example, pneumonias are rarely hospitalized now; nor are hernias, tonsillectomies, and even in some cases, normal deliveries. These are all treated on an outpatient basis. On the other hand, secondary and tertiary specialists who might be doing surgeries such as hysterectomies, total hip replacements, neurosurgery, etc. obviously still have need to hospitalize their patients. The secondary and tertiary specialists are, of course, much more predominant on the medical staffs of urban hospitals. Certainly the length of stay has dropped for all patients, but in the case of the Medicare Prospective Payment System, that is an advantage to the hospital, rather than a disadvantage since the DRG payment is made per case and not per stay. However, in the small rural hospitals, if the patient is never admitted to the hospital, the hospital suffers a severe loss of revenue.

Working together for a healthier you

For the last seven years I have been the administrator of Buffalo Memorial Hospital, a small rural hospital. In 1982 (our peak year), we had an average census in the hospital of 42 patients. So far in 1986, we have an average census of 19 patients in spite of the fact that we have added several doctors to our medical staff. It is not uncommon in rural hospitals to have the patient census be presently running approximately half of what it ran in 1982.

The differential between the urban and rural hospital payment rate for Medicare is adding a great deal of difficulty to the rural hospital financial picture. American Hospital Association 1984 data show that 66 percent of urban hospitals had more than 40 percent of Medicare revenue, where 70 percent of rural hospitals had more than 40 percent of Medicare revenue. This means that the rural hospitals suffer a penalty because they have more Medicare business.

Historical Costs:
The former Medicare cost-based reimbursement system was of course based on historical costs. Because of the spiraling costs to the Medicare Trust Fund, a new prospective payment system was instituted. This system was meant to foster competition and it has. Unfortunately, the cost-based part remains in determining the DRG payment. Since certain wages (not all) were lower in rural areas, it was determined that they should receive a lower payment rate. While the difference in rate is based on area wage differences, there are also economies of scale problems in the rural small hospitals which more than off-set any differences in wages. For example, a small hospital may have only eight medical/surgical patients in at a given time. This may translate, on a particular shift, to a need for one and one-half nurses. Obviously, the minimum that one can staff, for safe nursing, is two nurses. Consequently, it is more expensive because these same two nurses could take care of 12 patients rather than the eight they have.

Another problem with this differential based on urban/rural is for the hospitals that are very near metro areas and have to compete with those areas in the labor market. The two hospitals which I administrated for several years happen to be in this situation. One hospital is in the metro area by ten miles; the other is outside of the metro area by two miles. When the urban/rural rate is fully implemented, this will make a difference between these two hospitals of an average of $1,100 per DRG. Yet they compete in the same labor market.

I know of no other federally-funded program where there is a difference paid to people or facilities in urban versus rural setting. For example, the routine governmentally funded aid to schools per pupil has no urban versus rural basis, but is the same for all pupils. I believe this reflects the realization that there is a necessity for good education no matter where the pupil lives. I submit the same is true for health care.

Fairness Issues:
The ProPak Committee that advises Congress on the Prospective Payment System has testified that, even after allowing for area wage differences, lower intensity of services, and medical education requirements, the rural rate is still lower than the urban rate. This seems unfair since Medicare payments are made out of one common fund that is supported by us all. Eventually, the lower rural rate will translate into less desirable and less optimum health treatment which seems to single out rural residents unfairly, or will simply drive rural residents to seek care in urban settings--thus putting the rural hospitals out of business.

While some wages may be lower in rural communities, cost of supplies and other items tend to be higher, since small hospitals are not able to take advantage of economies of scale. Even if they do join a purchasing program, they pay higher shipping costs per item as well as being forced to buy whole cases of items which, for the hospital, may be a six-month supply rather than a two-week supply as it would be in a larger hospital.

If rural hospitals are forced to close, this will not take into consideration patient-borne costs, such as the cost of transportation to facilities that are farther away.

The Future:
Since the whole prospective payment system was developed to save money for the federal government, it would seem reasonable to preserve many of the small rural hospitals, since they have a much lower cost per admission than the urban hospitals. I am willing to see budget neutrality maintained on this issue. Metro hospitals have a much greater share of total revenue than rural hospitals do--I think the metro rate will only need to drop a small amount to bring the rural rate up to it.

Since the economic conditions in the rural areas are worsening daily, based on problems in the agricultural economy, it does not seem to make good sense for public policy to exacerbate that situation by paying lower and lower rates to rural hospitals, eventually driving them out of business. Driving the small rural hospital out of business will make a serious negative economic impact on the community. American Hospital Association data showed that in 1985 there were 61 hospital closures. Of those, 70 percent had fewer than 100 beds. There is no question in my mind, as I observe the financial situation in the rural hospitals with which I work, that the rural hospitals are in far more jeopardy financially that the urban hospitals, and much more likely to close.

This is the significant point I would like to make. If urban hospitals close, there are other urban hospitals in the area. If rural hospitals close, there may or there may not be rural hospitals nearby for rural patients to use. Certainly, with this lower utilization it seems reasonable that some of the smallest hospitals will close, and probably should close as acute care facilities. They should probably still maintain a health care presence in the community with emergency care, ambulatory care, and other health programs. I think the danger is, if several hospitals are financially forced to close that are located near each other, it may mean that people will have to drive 50 or 100 miles for hospital care. After the good work of the Hill Burton legislation many years ago that created our accessibility in the rural areas to health care, it seems destructive to allow that system to be dismantled because those hospitals are not receiving the same fair price in this new competitive environment that the urban hospitals receive.

Quality:
What relationship exists between small size and quality in hospitals? According to Ira Moscovice, from the University of Minnesota, size per se does not explain quality outcomes. So, when is small too small? With the changing practice patterns, it seems obvious that some consolidation is necessary and some hospitals will need to change their mission statements to produce more ambulatory service products rather than inpatient products. Nevertheless, much general acute care is routine and low risk and can be provided in a small intimate setting.

Issues of "personalness" and recovering in their own community with nurses whom they know are also quality issues. For the rural elderly in particular, it is extremely stressful to be driving to a metro hospital and hospitalized in a large, strange setting.

Accessibility:
Everyone agrees that many rural hospitals will close under our present reimbursement systems. Yet this will probably be a haphazard closing with no regard or plan for accessibility for rural Americans. In Wisconsin in 1984, one out of three Wisconsin hospitals had a net operating loss. If this is to continue, there is no question that hospitals will close.

It may make sense for the federal government to collect a pool of dollars through the capital payment system that could be used to retire the debt on hospitals which perhaps are not needed as acute care facilities. One of the big problems is that even if a community hospital feels its acute care facility is not needed, it probably has outstanding bonds that the governing board encouraged friends and neighbors to buy out of civic duty. It is very difficult at this point for a community governing board to advocate closure of the acute care facility even if it is not needed, knowing that friends and neighbors will suffer a loss on the bonds.

In light of the administration's proposed capital payment system it will, of course, be the hospitals that have high indebtedness, caused by having new or renovated facilities, that will close first since the capital reimbursement system being proposed will penalize them severely. Add that to the lower rural rate they are receiving for DRGs, and I'm afraid much of the rural health care system could come tumbling down before appropriate changes could be made to salvage it. I think it is very important for this committee to support legislation (if we must have a capital DRG system) that would give as long a time as possible to phase it in--Senator Durenberger has proposed seven years and I feel this is really a minimum. I think the administration's discussion of four years of phase-in will be disastrous, especially for the newer small rural hospitals.

What is Needed?

We need to abandon the urban/rural differential rate and go to one rate. That can be regional, if necessary, but the rural hospitals should not be penalized because they have been cost effective in the past.

We also need incentives for the smallest rural hospitals that are close to each other to:

- Change their mission to more of an ambulatory center;
- To help them consolidate;
- To handle long-term debt;
- To incorporate the hospital economy into the broader community economy.

We also need swing beds to be able to be used in hospitals larger than 50 beds. This has helped fill a need in rural hospitals, but the 50 bed limit is arbitrary.

And we also need access to capital as the plants age.

Thank you very much for the opportunity to testify today at this hearing on rural health care.

Senator **Durenberger**. Thank you very much. I thank all of you. I have the impression, now that we are concluded with this hearing, that we need to have more hearings. I think we have largely touched in all of the testimony on the PPS system why we need to change some parts of the PPS system. That is such a small part of the problem in rural health care delivery, as everyone of you has told us, that that is a problem that needs to be corrected in the overall solution of how we get access to quality care in rural America.

There are a lot of other things that we need to be paying attention to, some of which are in the jurisdiction of the Social Security Act. There are probably some other places, some of them are just what we ought to be advocating by our presence in various communities, whether we legislate it or not.

I think Max, this needs to be only the first effort that we make into this area. Before I finish, although I would like to ask Dr. Hayward if you would not give us your current view of the utility of peer review, of practicality of the way in which HCFA has approached and is approaching the recontracting of peer review.

Two Senators you have here are the only two that know a lot about peer review and we have all learned what we know from someone else like you. But, we are largely dependent on the ongoing effort to get some utilization, quality, and medical necessity and all the other things we are looking for. We really are very dependent on you and your colleagues to see the utility of peer review and the way in which HCFA approaches this whole thing and maybe if you would comment on that before we——

Dr. **Hayward**. Montana and Wyoming did not get their contract, they are not very happy about it. This is going to mean that we are going to have to do much more centralized review than we did before in order to stay within our budget, which disturbs us, especially in a large area like this. We would rather resolve the problems locally than if possible, rather than say having Washington, DC, West resolve the problems. We are finding ourselves getting further and further away from the real quality issues.

The only reason I got into this business some 14 or 15 years ago was because it was a quality program. It is becoming less of a quality program, more of a cost containment type of program.

We have a very difficult time at the—applying the same criteria, which we are supposed to do on quality issues on whether the patient is be admitted to the hospital at the rural level versus the urban level. For instance, the sophistication in the large hospitals outpatient surgery, for instance for general anesthetic is required. That, in order to have a successful outpatient you have got to have a very well greased oiled machine to make sure that the patient does not eat anything after midnight and various other things to follow up.

Small rural hospitals do not have that capability, they could not afford it, if they did have that capability. Therefore, they are more likely to put the patient in the hospital overnight. If we were to go by their criteria, strict criteria, we would say, no you cannot admit that patient. We are also trying to show some compassion. I am a physician adviser for one of my hospitals an outpatient cataract operation that was being done and he stayed in the hospital overnight and the physician wrote, "the reason I didn't send this patient home was because he is 80 years old, he lives a 100 miles from here and there is a blizzard out." I approved it, I broke the law, but I approved it.

Senator **Durenberger**. That is the issue I am getting at in terms of I do not know how many of these guys have ever lived in Montana or had to travel 100 miles to have an intraocular lens or something like that. And, the reality is that you look on the average or look at the capabilities of opthalmic surgery or whatever, and somebody can do the procedure in 17 minutes and whatever it is and you can be in and out. But, if you are 80 years old and if you have traveled 100 miles or even 40 miles, to have that surgery performed, there seems to me that there are a lot of surgeons, who would be very hesitant to put you right back into your car and send you home, knowing that if anything happened, you're 40, 50, 60, 70, 80, 90, or 100 miles away.

From what I hear in talking to people, some places in the larger towns, they're either building motels or something like that in connection with outpatient surgery centers. The reality is that, when you get to be a certain age, and a certain circumstance, not everybody goes in and out of this particular procedure. I would guess for every example like that, there are other examples that physicians could give us and I am concerned by a couple things. One is that HCFA is not sensitive to that as they set your contracts up. Also, that they are not very sensitive to the fact that you ought to be trusted a little bit more to use your own discretion about which hospital you ought to sort of zero in on or which physicians you ought to zero in on. They would more likely insist you watch all of the procedures and drudge up all the paper rather than letting you sort of make the decision, that these are the hospitals that we think in Montana or Wyoming, we ought to put a little special pressure on this year or whatever the case may be.

Max, do you have any.

Senator **Baucus**. Sterling, I wonder if you could address a question I have, that is, some folks have wondered whether the smaller rural hospitals have the capability to treat cases that are perhaps more sophisticated or more complex than some other cases. I wondered if you could address that question and maybe and in your answer also address the other side of that same point, namely in many cases the smaller hospitals can provide more in that there is a greater bond, a greater sense of trust. Closer personal relationship between hospital physicians and the community. Can you just address the quality of care in small rural hospitals.

Dr. **Hayward**. Thank you, Senator. As far as the quality in the small rural hospitals in Montana, we did have some problems way back in the PSRO days. I would say for all practical purposes, those have been resolved. Many studies were done, where it was suspected that maybe the physician was over his head in what he was doing, however, we found that they were really were doing a very good job.

The situation very often arises in a small hospital in a high risk area as far as injury is concerned, lumber, mining, and so on like that. You may find an orthopedic surgeon or you may find a general surgeon, whose services are really needed in that area and again if you evaluate the quality of that care that is being carried on in those areas it is high, it is good. And, that is in 50-bed and under hospitals, in fact they are doing just as good a job, probably than the larger hospitals are doing.

The problem that, that creates of course, when you get into, for instance, you get an orthopedic surgeon, such as I am in the small community with say around 50 beds and he starts doing total hips and total knees, the hospital loses money, because it is the DRG reimbursement is inadequate for that type of thing. I do know that because of malpractice threats and so on like that, that the rural physicians are shying away from doing things that they used to do, just because they are scared they are going to slapped with a law suit.

Senator BAUCUS. This panel, you have the last word here. You have been very patient, you have waited, given lots of folks your thoughts, some good points, maybe some points not so good. One basic question I have is the degree to which we should move toward a separate payment system for rural hospitals? Should we tinker with the two-tiered system and try to make it work or do you think there are just too many problems and we should have, a single payment system for all hospitals?

Should we go down one road?

Senator DURENBERGER. Is that a question for all of the panel?

Senator BAUCUS. Yes, just generally. I was curious if any of the panelists have any strong feelings about that.

Ms. KIECKER. Senator, I do and I think that we should go to a one——

Senator BAUCUS. You mentioned that in your testimony, I appreciate that.

Are there any here that disagree with that? You think we should tinker with the present two-tier?

Mr. BECK. I think we can tinker with it all we want, but if it does not—if we do not go far enough in the tinkering to resolve the problems that we have now then we——

Senator BAUCUS. So, you are saying do not tinker, just make some dramatic changes.

Mr. BECK. Yes.

We are at the point where dramatic changes are needed.

Mr. TREMBULAK. I think there is a certain degree of information that still needs to be brought in and I think the inquiry into the studies is very important to get that data to further pursue this avenue.

Senator BAUCUS. I appreciate that and just think of the frustration we all have in having to get policymakers in Washington urban areas to understand feel, sense, taste, and smell what is and like to live in rural America, where there are vast spaces. I think too often people in Washington, HHS, HCFA, or for that matter, Members of the House and Senate, who spend too much time in this town. So we try to solve problems by looking at memos and reports and so forth, we just do not have the practical experience, and we have not internalized the problems that rural America faces, practicularly because of the vast distances and spaces.

I have many time encouraged Members of the House from very urban areas to come to Montana. I can tell you, that when they do come out they are agog at the sense of space. It just blows them away. They have never come up against something like that. I do not know how long that remains with them. They come back to their towns and urban areas where they live, I am sure some of that is forgotten, but still basically, this is something I thing is very important. I wish there was some way for policymakers to get out in vast areas and see that.

If they only knew. Sterling, in watching you give your presentation there, showing how far the distance is from Alzada to Yaak, reminds me of when I first ran for Congress. That was 12 years ago, and I walked across our State. I started out in a little town, it was not Alzada, but I ended up in Yaak. The fact of the matter is somewhat appropriate, because I started out in as luck would have it, in a blizzard and I walked 24 miles that day. There were photos nationwide and in Europe, but none of them in my homestate papers. [Laughter.]

The fact is that by the end of the first day I had terrible case of shin splints. I could hardly walk. I must say there was no hospital, there was no physician. I spent the night in a camper that night and the next morning I woke up it was 10 or 20 below and I could barely walk as I had this terrible case of shin splints. I knew then that I had to keep going, you just do not stop for something like that. Anyway, I hobbled to the nearest thing to a hospital in a place called Chico Hot Springs, just outside of Paradise Valley in our State and I sat in the hot springs for a day, hoping the warm water would cure my shin splints. But I must tell that did not work either. So, I hobbled, and 2 days later, I ended up in Livingston, MT. I went to see a doctor there in Livingston and I must say he did not——

Senator **Durenberger**. He prescribed getting out of the way. [Laughter.]

Senator **Baucus**. But, I finally made it over——

Senator **Durenberger**. Not a Republican doctor.

Senator **Baucus**. I went to Bozeman, MT a couple of days later, till hobbling and met a fellow named Gordon Herbick, who was the trainer for the Montana State University track team and he knew what to do. He took care of my shin splints and in about 2½ months later, I made it to Yaak. Well, Yaak is really just the end of the line, I mean it is in a logging community, and not many folks live in Yaak. Yaak is really cold. There is not really a town called Yaak, it is called The Yak. The Yaak is an area way up in the extreme northwest part of our State and there is another kind of institution there to help cure people's ills, and that is the only institution in the Yaak and that is the bar. There is a bar in the Yaak that is called the Dirty Shame.

Dr. **Hayward**. It is now closed. [Laughter.]

Senator **Durenberger**. That's a dirty shame. [Laughter.]

Senator **Baucus**. But, I just wish that HCFA and others could accompany me on that roughly 3-month trek across the State. You get a sense of distance, you get a sense of space and you just get a sense of how far it is one place to another.

Another time I brought back a fellow named Nick Kelley with the National Health Service back to Montana. This is when HEW came out with a National Health Care Guidelines. It would have had the effect of closing a lot of rural hospitals. To be eligible to get Medicare payments you had to have 80-percent occupancy or something like that. If you had a pediatric ward, you had to have 20 beds. I do not know all that there was. There was just a lot of stuff that small hospitals simply could not meet and it would have forced the requirements on those hospitals.

Well, I brought back Nick Kelley from Denver to Montana. At that time, and still now, there are lots of town meetings. A certain number of people would show up at town meetings across the State. Well, at that time I brought Nick Kelley back, I must tell you that the number of people, who came to town meetings in towns like Deerlodge and Conrad, small towns in Montana with small hospitals, and Anaconda, MT. The number of people, who came to those town meetings, dramatically increased fourfold or fivefold. Literally you could not get anyone else in the room. They were hanging from the rafters and I tell you they wanted to lynch this guy Kelly. And, we were very lucky because as the State would have it, I brought Nick Kelly back into some more blizzards. We were trying to get from one town to another, as we were pointing out how hard it is to get from one town to another. We all know how much mail we receive on lots of issues, Panama Canal for example and other issues. I got as much mail from folks at home on those health care guidelines as I have ever received on anything else.

So, I got all this mail and I put it in five mail sacks; that is what it took. The mail took up 5 sacks, 10,000 letters that I got in about a week, which is a lot for Montana standards.

Someone in my office had a pickup truck. So we put these mail sacks in the pickup. I drove downtown over to HEW, and Joe Califono was then Secretary of HEW. We went up the elevator, we took the mail sacks off and put the mail sacks on his desk. At that time, he had one arm in a sling, he broken his arm or something. I told him if he did not——

Senator **Durenberger**. That would keep him from smoking.

Senator **Baucus**. If, he did not repeal those health care guidelines a lot of Montanans would make sure his other arm would be in a sling. [Laughter.]

The fact of the matter is that he got mail from all over the country and it was not just from Montana and that is the one time I saw the Department react.

Senator **Durenberger**. Really.

Senator **Baucus**. Favorably, and I just hope that HHS and HCFA get the message and we do something about this problem. It is a severe problem that we are talking about here. It is a real problem, it is not just talk, it means a lot to a lot of folks, and I am a little sorry that Mr. Fleming has left.

Senator **Durenberger**. He had to make a speech at 12:30.

Senator **Baucus**. I was going to first, thank him for staying through an entire hearing and second, ask him if he had any comments, any reactions that he had at this point.

Senator **Durenberger**. Hal or Bob do you want to say anything? [Laughter.]

Come on. [Laughter.]

Senator **Durenberger**. Come on. Do you have any stories about your last trip to Montana? [Laughter.]

Good for you.

Well, anyway, thank you all very much, we appreciate you being here, the hearing is adjourned.

[Whereupon, at 12:55 p.m., the hearing was adjourned.]

[The followup answers to questions asked by the committee follow:]

[By direction of the chairman the following communications were made a part of the hearing record:]

OLP; Action

OC Fleming; Desmarais
AAP: AAEA: AAMSS: AAO
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United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510

May 15, 1986

Mr. Bartlett S. Fleming
Acting Deputy Administrator
Health Care Financing Administration
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Fleming:

To follow-up on your testimony at the May 9, 1986 Subcommittee on Health hearing on the status of rural hospitals under the Medicare program, Senators Packwood, Durenberger, Baucus and Mitchell would like you to answer the attached questions.

Your response should be typed on letter-size paper and double spaced. To meet our printing schedule, please provide your answer no later than June 6, 1986. Send your response to:

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, D.C. 20510

If you have any questions, Ms. Salmon may be reached at 202/224-4515.

Sincerely,

EDMUND J. MIHALSKI, C.P.A.
Deputy Chief of Staff
for Health Policy

cc: Toni Davenport

Senator Durenberger

1. Q. In your written testimony you cite a Rand study which derived cost estimates from preliminary cost reports and sample claims data. HHS extrapolated the Rand data and concluded that the majority of rural hospitals improved financially. How much confidence can we have in this conclusion, since it was based on preliminary, sampled data?

A. We have a great deal of confidence in the conclusion that a majority of rural hospitals have improved financially insofar as Medicare PPS cases are concerned. Our conclusions were quite similar to those reported by the HHS Office of the Inspector General (OIG) from their eight State study.

Our analysis used the latest available cost reports from nearly 5000 hospitals, including about 2500 rural hospitals, and all of the FY 1984 PPS claims from those hospitals. Although not all of the cost reports were audited and settled, we believe that underpayments and overpayments determined in final settlements largely offset each other. We are quite confident that the method does not bias results for any type of hospital. Later this year, as more hospitals' Medicare cost reports for their entire first accounting year under PPS become available for analysis, we intend to validate these estimates.

Senator Durenberger

2. Q. How might a more equitable outlier reimbursement policy be developed for rural hospitals?

A. We plan to explore several approaches in the study mandated by section 9113 of Public Law 99-272. One approach would consider separate outlier threshold calculations for urban and rural hospitals. Another would consider a separate payment formula for outlier cases in rural hospitals. These two approaches might also be blended. In addition, we will examine whether standardizing all hospitals reported costs to take account of their actual outlier case payment experience would be feasible.

We have not concluded that the present PPS method for defining and paying outliers is inequitable. We recognize that the outlier thresholds used in 1984 and 1985 were largely based on pre-PPS Medicare claims and did not arbitrarily assume that PPS would dramtically lower average lengths of stay. In developing 1986 outlier thresholds, we took PPS claims experience into account. However, the emergency extensions prevented these from going into effect until May 1, 1986. Hence, when one year of PPS claims experience becomes available starting with May 1, 1986, we will then be able to determine whether we might have already achieved the equity we seek.

Senator Durenberger

3. Q. A witness before the Committee testified that approximately 600 rural hospitals are likely to close by the year 2000. How did you reconcile this estimate with your statement that all hospitals, including rural facilities, have experienced a general improvement in their financial position since the introduction of PPS?

A. First, let me clarify by saying I did not state that every hospital has experienced improvement in its financial position since the introduction of PPS. I said "hospitals in both urban and rural areas experienced a general improvement in their financial position," and "a large majority of both urban and rural hospitals showed a positive margin over their costs for Medicare patients."

All of the studies we have seen suggest that hospitals generally have become better off, although rural hospitals have not done as well as urban hospitals.

We cannot confidently say whether the prediction you heard is correct. We have not seen its assumptions or methods. But, we do know that in designing PPS the special needs of sole community hospitals and rural referral centers have been considered, and special added payment features are in effect. These might not be sufficient to assure that financial viability of all such hospitals --but they are a visable commitment of the Medicare program to pay more for care of its beneficiaries in these special circumstances.

Also, care must be taken to understand what is meant by a hospital "closing". In HCFA's experience, many hospital "terminations" from Medicare participation are in fact an aspect of changes in ownership, and mergers or changes in the facility mission. In our opinion, these market dynamics occur because of general local economic situations, not because of Medicare's payment policies.

HCFA has directed both of its research centers in the coming year to examine the long run impact of Medicare's PPS on rural hospitals. Their first task is to develop a realistic design for such a study that is based upon recent empirical experiences. We believe that an appropriate study is likely to take several years before we can be reasonably confident about the certainty of predictions. Meanwhile, we will continue to pay special attention to the short run impacts of Medicare's PPS on rural hospitals in the studies performed for the Secretary's Annual Report to Congress and in our continuing rule-making processes.

Senator Durenberger

4. Q. How much, if any, research and demonstration money does HCFA's Office of Research and Demonstrations set aside for projects addressing rural hospitals?

A. HCFA's Office of Research and Demonstrations develops an annual Research, Demonstration, and Evaluation Plan reflecting proposed initiatives and associated levels of funding. In the FY 1986 Plan, there were specific projects focusing on such rural issues as sole community hospitals, regional referral centers, the feasibility of eliminating separate urban and rural PPS rates, and designing a study of the long-term impact of PPS on rural hospitals. This latter initiative will be continued and further expanded as a result of the Senate Appropriations report requesting a study of the long-term impact of PPS on rural areas. We spent approximately $300,000 on these external projects in FY 1986.

In addition, the impact of PPS on rural hospitals has been a special focus of nearly all PPS impact studies. For example, in FY 1985, we awarded a contract to Abt Associates to conduct a series of analyses of issues related to PPS refinement/impact. Almost one-third of the nearly $2 million worth of tasks under the contract to develop a PPS impact data base will involve rural hospitals or beneficiaries' data inputs.

Other high priority study topics, such as the adequacy of outlier payments, DRG refinements for severity of illness or intensity of care, financial viability, wage differences, etc., will also separately examine the expected impact upon rural hospitals. This has been true also for studies performed thus far to simulate the impact of changes in PPS payment rates.

We continue to invite, through our grant and cooperative agreement solicitation, proposals to study issues concerning rural hospitals; and we are committed to continuing our current study initiatives in this area.

Senator Durenberger

5. Q. As you stated, sole community hospitals can receive an additional payment amount, if due to certain circumstances, they experience a decrease of more than 5% in their number of inpatient cases.

Later testimony stated that the process for applying for this adjustment can impose a substantial financial burden on small, rural hospitals. What can be done about this problem?

A. Given the current statutory construction that specifies that such payments fully compensate the hospital for the fixed costs it incurs in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services, we see little alternative to the current process. In order to make the determination required by the statute, we need all of the information requested.

We have evaluated alternative methods of making payment to sole community hospitals to compensate for volume declines as part of our research for the report to Congress on this subject as required by the Social Security Amendments of 1983. However, we believe any formula-based method of providing for volume-related payments would require legislation.

Senator Durenberger

6. Q. Some argue that criteria for referral center classification are too restrictive, particularly in light of the decline in admissions since PPS was implemented. Much of that criticism is based on the "6,000 minimum discharge" requirement.

Do you agree with the criticism? How would you modify the classification criteria in order to fix the problem?

A. We do not agree that the criteria are too restrictive.

There was no existing definition of referral centers at the time the original PPS legislation was passed and Congress legislated that an exception or adjustment should be made for such centers. Therefore, we relied heavily on congressional discussions in establishing criteria to define such centers. Throughout such discussions were references to "large" rural hospitals. Thus, as one criterion which must be met to qualify for the rural referral center adjustment, we established a number of discharges standard to recognize those rural hospitals which treat a disproportionately larger number of patients than do the average general community hospitals.

In addition, based on the Deficit Reduction Act of 1984, we expanded the discharge criterion to permit comparison of a rural hospital's number of discharges to those of a typical urban hospital in the same census region.

Thus, a rural hospital can qualify by having an annual number of discharges equal to or greater than a national or a regional urban standard.

In proposed regulations published in June 1986, we are proposing to lower the national and regional number of discharges benchmarks by 8.05 percent. This figure is based on the American Hospital Association's (AHA) panel survey data which show that the percent of admissions to acute care hospitals has declined by 8.05 percent from 1981 through September 1985-the most current data available. The proposed national number of discharges to qualify as a referral center is 5,517.

Senator Packwood

1. Q. Regarding the number of hospitals currently designated as either sole community providers, rural referral centers, or swing bed facilities, in your opinion, are these numbers sufficient to meet the existing needs of the rural population? Do you expect substantial increases in any of these categories?

A. There are currently 165 rural hospitals qualified as referral centers.

Since this provision was originally established to recognize those rural hospitals which are larger, more technologically sophisticated, draw patients from larger than average geographical areas, and which more closely resemble their urban counterparts than do the average rural community hospitals, we believe our criteria are fair and sufficient to protect true rural referral centers.

The rural referral center adjustment is granted for a 3-year period. Since most existing centers qualified during FY 1985, we do not expect any reduction in the number until at least FY 1988. In addition, because we are annually adjusting the case mix index and number of discharges standards based on national trends we do not expect any substantial variations at a later time.

Moreover, we do not expect a substantial increase in the number of sole community hospitals. The criteria that we use to make such designation are based on factors, such as distance from neighboring hospitals, that are unlikely to significantly change at a rapid rate. We believe most hospitals that meet the criteria have already applied for sole community hospital status.

We believe the number of rural referral centers is adequate for the current needs of rural communities. While the number of swing bed hospitals continues to grow, the pace of that growth is slowing somewhat. This may indicate that we are reaching an adequate number of swing bed hospitals as well. The payment system, however, is designed with enough flexibility to allow entry of additional rural referral centers or swing bed hospitals should changing market conditions enable hospitals to meet the criteria.

Senator Packwood

2. Q. Many advocates of rural hospitals argue that these hospitals are essential in order to attract and retain physicians in rural areas. They claim that local physicians would leave the area if a hospital closed. Do you agree or disagree with this viewpoint?

A. Studies on the availability of medical care have described a growth in the overall supply of physicians. The greatest impact in rural areas has been seen through the increase in the number of specialists. Moreover, many general and family practice physicians are now practicing subspecialties as well. As the physician pool expands, we expect access to specialty care for rural and small-town residents to continue to show improvement.

Additionally, we are seeing a growth in alternative health care settings such as ambulatory surgical centers and community health centers. More physicians, both general practitioners and specialists, are being attracted to suburban and rural areas as development of these and other outpatient facilities continues.

We believe these trends will offset any negative impact on the supply of physicians resulting from hospital closures.

Senator Mitchell

1. Q. A number of hospital administrators in Maine have expressed their opposition to the differential in urban/rural payment based on wage differences. One administrator in Ellsworth claims that he must compete for hospital personnel with the Eastern Maine Medical Center, located in Bangor. The Ellsworth hospital is reimbursed at the rural rate, and the Bangor hospital at the urban rate.

Does this situation occur often? Is there really a significant difference in wages which those in rural areas expect to be paid as compared with those in urban area? In other words, is it fair to reimburse rural hospitals at a lower rate based on the belief that if a hospital is in a rural area its labor costs must be lower than urban hospitals?

A. Your question concerns the propriety of the rural hospital wage index for rural hospitals located close to hospitals which are classified urban.

Section 601(e) of the Social Security Amendments of 1983 requires that payments to hospitals be established on the basis of geographic region and urban/rural location.

The law further defines an urban area as an area within the boundaries of a Metropolitan Statistical Area (MSA), as designated by the Executive Office of Management and Budget, or within such similar area as the Secretary has recognized in accordance with the regulations establishing limits on hospital inpatient operating costs under the Tax Equity and Fiscal Responsibility Act of 1982. Counties within a State outside the designated metropolitan areas are considered rural.

Although we are required by law to maintain an urban/rural distinction in administering the prospective payment system (PPS), we recognize that certain hospitals, particularly rural facilities located in counties adjacent to urban areas, maintain that they are disadvantaged by this policy because they incur costs comparable to those of urban facilities.

We have reviewed the particular situation to which you refer. The rural hospital involved is Maine Coast Memorial Hospital (MCMH), located in Hancock County. Based on the 1982 data used to construct the hospital wage index used in the PPS, MCMH has an average hourly wage of $6.73. The average for rural Maine is $6.90 while that for the Bangor MSA is $7.40. Based on this comparison of hospital wage levels, MCMH's classification as a rural hospital would not appear inappropriate since its wages are more similar to the rural Maine average than to that for the Bangor MSA. Eastern Maine Medical Center's corresponding average hourly hospital wage is $7.46.

Generally, rural hospitals on average pay lower wage levels than urban facilities. However, the broad implication of your question is that an alternative means for aggregating counties to develop rates more reflective of economically integrated areas needs to be investigated. We have acknowledged the need for further research in this area and are examining a number of alternatives.

However, because of the considerable financial impact that abruptly revising the current urban/rural classification system would impose, we intend to proceed carefully.

In this connection, it should be noted that the prospective payment legislation requires the Department of Health and Human Services to study and report to Congress on the feasibility and impact of eliminating or phasing-out separate urban and rural payment rates. This report will enable us to determine the extent to which changes in the urban/rural classification system are necessary and appropriate.

I should point out that any changes to the present urban/rural hospital classification system will not avoid the kinds of problems implied by your question. Any new boundaries will always result in some hospitals being relatively disadvantaged because of their location vis-a-vis the boundary drawn. There will always be rural hospitals whose wage levels are more similar to those for nearby urban areas and vice versa.

However, this does not impugn the overall validity of the urban/rural classification system used in the PPS.

Senator Mitchell

2. Q. In Maine, many rural hospitals are experiencing a decline in occupancy rates. At the same time, we have a shortage of long-term care facilities in almost all parts of the State.

Aren't there viable alternatives for utilizing empty beds in rural hospitals?

How difficult is the "swing bed" approach to establish? In Maine, a number of persons in the health community, including our Commissioner of Human Services, believe that the "swing bed" concept is very difficult to set up and to establish a workable reimbursement scheme. Have other States had measured success with swing beds? How has the reimbursement system been anticipated?

A. There are two alternatives available for rural hospitals to utilize their empty beds. One would be the swing bed program which is available to rural hospitals having less than 50 beds. The swing-bed program allows small rural hospitals to receive Medicare reimbursement for providing long-term skilled nursing facility (SNF) care in acute care beds. That is, the beds can be used interchangeably for acute care and long-term care services that are reimbursed at commensurate levels.

A second alternative available to all providers permits hospitals to establish a distinct part SNF. This would consist of a hospital converting a portion of its acute care beds into SNF beds.

To be eligible for the national swing bed program, a hospital must be located in a rural area and have fewer than 50 beds in use. We have used the interpretation of the statute that allows the greatest number of hospitals to qualify. To participate, an eligible hospital must receive a certificate-of-need from the designated State agency in States where the certificate-of-need requirements include expansion to swing bed care. To be certified to provide skilled care to Medicare swing bed patients (and Medicaid swing bed patients if the State Medicaid agency has elected to participate), the hospital must also satisfy six of the skilled nursing home facility (SNF) conditions of participation required of nursing homes in the areas of patient activities, patients rights, discharge planning, dental services, social services, and specialized rehabilitation services.

Preliminary studies of the swing bed program indicate that the establishment of the program by Federal and State agencies required few resources for incorporation into their existing operations. Implementation usually required no new personnel, merely a shifting of existing personnel (estimated cost was typically less than $5,000/year per agency).

About one-third of the eligible hospitals in rural areas are now certified to provide swing-bed care. In fact, the number of certified swing bed hospitals represents approximately 10 percent of all hospitals in the U.S. As of January 1, 1986, there were 771 hospitals in 38 States participating in the swing bed program and the total number is continuing to grow. In most locations, the swing bed approach is viewed as providing a valuable community service in rural areas, especially since it allows more patients with skilled care needs to remain in their home communities after discharge from acute care.

Medicare reimbursement for routine SNF services in swing bed hospitals is, by statute, made at the average rate per patient day paid for SNF routine services under the State's Medicaid plan during the prior calendar year. Medicare payment for ancillary services is made on a reasonable cost basis.

Senator Baucus

1. Q. In the conclusion of your testimony, you state that the department believes that HMOs offer attractive benefits to Medicare patients and providers. Since almost all Medicare HMOs are located in urban areas, and the projects located in rural areas experienced financial problems, what leads you to believe Medicare HMOs can be successful in rural communities?

A. Experience to date indicated that most prepaid plans are established in urban areas. We speculate that in many instances prepaid systems have not been attracted to rural areas because the average adjusted per capita costs (AAPCC) rates are higher in urban areas and because a prepaid system requires a fair size of enrollment base in order to spread the risk. The enrollment base required may not be attainable in rural areas.

Also, until recently, most prepaid plans were staff or group practice model HMOs relying on established locations where enrollees must go to receive care. This restricts the enrollment of interested persons to those living in relatively close proximity to these delivery sites.

Recent trends indicate a rapid entry into the prepaid market by Independent Practice Associations (IPA) and other alternative delivery systems which can accommodate a wider geographic dispersement into the community since physicians generally deliver care from their individual offices. For instance, we are aware of several preferred provider type organizations that operate statewide.

We anticipate that this trend will result in a variety of capitated systems being available to rural beneficiaries in the future. Certain of these organizations may already be capable of qualifying to contract with HCFA on a risk basis.

We anticipate testing the voluntary voucher program on a demonstration basis in the near future and have incorporated rural areas into the demonstration design. In addition, HCFA has been considering testing the concept of geographic capitation, in part to overcome the problem of capitating rural areas. This concept involves one organization being at-risk for all beneficiaries in a geographic area, resulting in an environment where both rural and urban areas would be capitated.

Senator Baucus

2. Q. Testimony given by HCFA at the Ways and Means Committee hearing on Medicare contracting indicating that claims payments would be slowed to an average payment time of 30 days under part A and B by the end of FY 1986. Testimony given by Blue Cross/Blue Shield at the same hearing indicated that the providers who would be most adversely affected by this slow down are those which do not have electronic billing, are not on periodic interim payment (PIP), are smaller providers, and have a high percentage of Medicare claims. Rural hospitals fit all these criteria. Were the particular problems of rural hospitals taken into account in formulating the claims slowdown policy?

A. We realize that the increase in payment times has affected some providers more severely than others. We are reviewing the situation to ascertain if payment times can be reduced where necessary.

The increase in payment times has been caused by two factors -- a tight budget and an unanticipated claims volume growth. The tight budget is a result of the Gramm-Rudman-Hollings mandated reductions of 4.3 percent from the Medicare contractors' Congressional appropriation of $963 million, plus a $15 million contingency. This reduction has necessitated an increase in claims payment times above previous levels.

In addition to the Gramm-Rudman-Hollings cuts, claims volume has increased dramatically beyond out estimates, especially under part B.

This growth is caused by a large increase in outpatient claims which appears to be a response to the prospective payment system for inpatient hospital services. Physician, durable medical equipment (DME) and laboratory claims have increased substantially. Physicians appear to be submitting fewer services per claims, the Deficit Reduction Act of 1984 changes to laboratory reimbursement has spurred increases in those claims and DME marketing activity has increased. We are continuing to study the volume increase and proposed solutions to it.

In spite of the Gramm-Rudman-Hollings cuts and the unanticipated volume growth, we are pledged to hold claims payment times to 27 days. Money will be made available to contractors to at least maintain a 27-day cycle.

Senator Baucus

3. Q. If the goal of HCFA is a 30-day average claims payment cycle, what will be the payment time for small rural hospitals who meet the criteria I have just described?

A. The same claims payment cycle will apply to rural hospitals. Funding will be made available to at least maintain a 27 day cycle at each contractor.

Senator Baucus

4. Q. Small rural hospitals comprise a significant portion of the hospitals in the United States, many of which are experiencing financial distress, yet the research and demonstration programs carried out by HCFA have very few projects relating specifically to rural hospitals. Other than the swing bed projects and the Finger Lakes Area Hospitals' Corporation, are there any other research and demonstration projects being conducted or planned by HCFA which relate specifically to rural hospitals or rural health care?

A. HCFA's research and demonstration programs attempt to demonstrate or evaluate the affects of various payment methods on a broad spectrum of providers. As such, there are few projects which focus exclusively on any one provider segment such as rural swing-bed hospitals or rural health clinics. Our hospital demonstrations have been conducted on a statewide basis or in a broad geographic area in order to assure an appropriate mix of providers. For example, our statewide demonstration with the State of Washington included numerous rural hospitals. On the other hand, since our demonstration with the Rochester Area Hospitals' Corporation could only include urban hospitals, the same payment method was replicated in a rural area with the Finger Lakes Hospitals' Corporation. Other examples of large demonstration initiatives which have included rural sites are the National Long-Term Care Channeling Demonstrations and the AFDC Homemaker/Home Health Aide Demonstrations.

We are presently conducting research intramurally and through the Brandeis Research Center which is addressing the rural issues raised in P.L 98-21, P.L 98-369 and P.L. 99-272. These topics include:

- Sole community hospitals' susceptability to large occupancy declines;
- Appropriate adjustments for large rural teaching hospitals and regional referral centers;
- The feasibility and advisability of eliminating or phasing out separate urban and rural rates;
- Identification of DRG's having large non-labor related cost shares;
- The desirability of maintaining a regional component in the PPS rates;
- Alternative payment blending methods including but not limited to methods which take into account cost variations within DRGs;
- Impact of PPS transfer and outlier case payment policies on small rural hospitals; and,
- Long run impact of Medicare's PPS on rural hospitals.

Rural areas and hospital impact is also an important aspect of our research studies of PPS impact on types of hospitals, beneficiaries, other providers and other payers of capital, DRG refinement for severity of illness or intensity of care, options for SNF prospective payment, options for prospective payments of outpatient services, options for payment of Certified Registered Nurse Anesthetists, options for paying physician services, and, of course, approaches to expanding capitation arrangements for Medicare beneficiaries.

Senator Baucus

5. Q. When HCFA promulgates regulations, how often is a regulatory flexibility analysis done, and can you describe any regulatory flexibility analysis which was done specifically to analyze the effects of a regulation in small rural hospitals?

A. For every regulation, HCFA makes an explicit determination whether or not a regulatory flexibility analysis will be performed. Generally, if there is doubt as to whether an analysis would be required under the terms of the Regulatory Flexibility Act, (RFA), we prepare and publish an analysis voluntarily. We consider all hospitals to be small entities within the meaning of the RFA, and we therefore routinely prepare regulatory flexibility analyses for regulations that would have a significant economic impact on a substantial number of hospitals. In many such analyses, including the analysis of the impact of prospective payment regulations published in 1985 (NPRM - June 10, 1985; Final - September 3, 1985) we have explicitly considered the effects on rural hospitals.

Senator Baucus

6. Q. Regulations which were proposed on March 10, 1986, provide for adjustments in the hospital-specific base amount for sole community providers which experience significant cost distortions because of new services related to community medical needs. This is an important provision, since 75 percent of the payment to a sole community provider is based on the hospital-specific base. However, these regulations require that:

-- The provider must request the adjustment from the intermediary and document the need for the adjustment;

-- The intermediary must forward this information with its recommendation to HCFA within 90 days;

-- HCFA has 90 days to approve or disapprove; and

-- The adjustment does not apply until the cost reporting period beginning after the approval.

This could mean a delay of as much as 18 months from the time the new services is added to the time the payment amount is changed. Why is this adjustment limited to cost reporting periods which begin after HCFA approval?

A. The March 10, 1986 proposed regulations concerning adjustment of the hospital specific rate for sole community hospitals would provide for adjustment of the prospective payment rate only after approval of a hospital's request.

Our decision in proposing this effective date was heavily influenced by the very nature of a prospective pricing system. That is, we believe the concept of prospective pricing clearly implies that retroactive adjustments of the payment rates are inappropriate under all but extremely rare instances.

Further, we believe retroactive rate adjustments dilute the incentives inherent in the prospective payment system (PPS). If hospitals recognize that they would retroactively recover the full costs of adding new services and that future payments will be based on those initial year's costs, there is a significant incentive to escalate costs rather than to institute appropriate efficiency measures. Congress expressly recognized this flaw in the retroactive payment system in enacting the PPS.

Section 9111 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) provides for payment adjustments for sole community hospitals similar to that proposed in the March 10, 1986 Federal Register.

This section specifies that such adjustments apply to payments for cost reporting periods beginning on or after October 1, 1983 and before October 1, 1989.

Senator Baucus

7. Q. For participating rural referral centers, please provide information, by state, on the case-mix and qualified discharges (i.e., discharges counted toward determining rural referral status) for 1983 through the year for which data are currently available.

Please provide 1985 case-mix and discharge information by State for any rural referral center where 1985 data are now available.

Also, please indicate the number of excluded discharges for each rural referral center (i.e., discharges not counted in determining rural referral status).

A. HCFA does not routinely collect all the information requested. Individual hospitals submit data to the regional office for approval as rural referral centers (RRCs). This data is not centralized, nor is it consistently maintained by regional offices since RRC status is determined on an individual basis. In addition some of the data requested for review by the regional office such as the number of excluded discharges, are either not provided in the cost report or otherwise uniformly reported. Therefore, many regional offices do not retain the data beyond the point of status approval. Future reviews will determine continued RRC status based on data current for that time period; past data will not have a bearing on the decision.

We have received cost data for "PPS-1", the first year of experience under the prospective payment system and are therefore able to provide discharges and case-mix data for 157 RRCs. It should be noted that some of the data are taken from unaudited cost reports, and are therefore subject to adjustment. A list is attached containing the available information.

Eight RRCs for which 1984 cost data are not available are also included in the listing. Although we do not have the total number of discharges for these eight hospitals, total Medicare discharges for FY 1984 and case-mix indexes for FY 1984 and FY 1985 are shown.

REGIONAL REFERRAL CENTERS

Hospital	Case Mix FY 84	Case Mix FY 85	Total Discharges FY 84	Medicare Discharges FY 1984
ALABAMA				
East Alabama Med. Ctr.	1.0915	1.13468	11,773	3,083
Selma Med. Ctr. Hosp.	1.0387	1.11159	6,671	3,039
ALASKA				
Fairbanks Mem. Hosp.	1.0635	1.08617	8,068	749
ARKANSAS				
Central Ark. Gen. Hosp.	0.9729	1.08243	5,222	2,698
St. Bernards Reg.Med.Ctr.	1.1122	1.13877	13,795	4,986
St. Mary's Hosp., Inc.	1.0406	1.09116	5,782	2,469
Chickasawba Hosp.	1.0360	1.03811	6,740	2,030
Quachita Mem. Hosp.	1.1065	1.17644	6,326	1,700
Warner Brown Hosp.	1.0401	1.10249	N/A	2,666
Union Med. Ctr.	1.0756	1.11493	5,477	1,714
CALIFORNIA				
Sierra Vista Hosp.	1.1303	1.20772	6,856	2,845
COLORADO				
St. Mary's Hosp. Med. Ctr.	1.1290	1.24699	9,732	2,929
CONNECTICUT				
Day Kimball Hosp.	1.1696	1.08741	6,313	2,364
DELAWARE				
Kent Gen. Hosp., Inc.	1.1521	1.21361	6,985	2,263
FLORIDA				
Indian River Mem. Hosp.	1.0959	1.10838	10,859	5,153
Fawcett Mem. Hosp.	1.1349	1.16481	6,692	3,814
GEORGIA				
Hamilton Med. Ctr.	1.1003	1.07547	N/A	3,278
W. Georgia Med. Ctr.	1.0504	1.11790	10,371	3,928
Glynn Brunswick Mem.	1.0750	1.12372	15,253	4,315
John. D. Archbold Mem.	1.1199	1.12682	10,509	3,500
Floyd Med. Ctr.	1.0891	1.14660	13,254	3,942
Tift Gen. Hosp.	1.0305	1.11135	9,680	2,855
S. Georgia Med. Ctr.	1.1197	1.15947	12,859	3,401

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IDAHO

St. Joseph's Hosp.	1.0777	1.13571	7,309	2,554
Mercy Med. Ctr.	1.0297	1.08843	5,899	2,110
Caldwell Mem. Hosp.	1.1447	1.16562	5,191	1,706
Idaho Falls Cons.	1.1676	1.15744	12,206	3,097
Bannock Mem. Hosp.	1.1025	1.12405	6,262	1,253

ILLINOIS

Blessing Hosp.	1.0944	1.10995	9,691	3,644
Freeport Mem. Hosp.	1.0213	1.12084	N/A	2,748
St. Mary's Hosp.	1.0859	1.11061	6,136	2,259
Memorial Hosp.	1.0575	1.13670	7,622	2,117

INDIANA

La Porte Hosp.	1.0805	1.13760	7,435	2,389
Marian Gen. Hosp.	1.0344	1.13132	10,828	3,848
Reid Mem. Hosp.	1.0583	1.15521	11,842	4,113
Caylor-Nickel Hosp.	1.1251	1.15438	5,199	1,768
Bartholomew Co. Hosp.	1.0004	1.13096	13,345	3,813

IOWA

Marshalltown Area Hosp.	0.9218	1.15988	7,298	3,662
Trinity Reg. Hosp.	1.1513	1.22445	5,668	2,762
Greeley Mary Med. Ctr.	1.1461	1.24952	8,409	2,928
Burlington Med. Ctr.	1.1098	1.16782	N/A	3,222
St. Joseph Mercy Hosp.	1.1132	1.19554	8,614	4,116
Ottumwa Hosp.	1.0768	1.15056	5,031	1,925

KANSAS

Asbury Hosp.	1.2546	1.27799	6,320	2,102
Halstead Hosp.	1.2393	1.21987	4,707	2,040

KENTUCKY

Highlands Reg. Med. Ctr.	0.9594	1.03524	7,988	2,195
Med. Ctr. Bowling Green	1.0426	1.14339	12,623	3,007
Murray-Calloway Co.	0.9519	0.98701	6,662	2,274
Ephraim Mcdowell Mem.	1.0751	1.08995	6,096	1,856
Pattie A. Clay Inf.	1.0180	1.09528	5,655	1,492
Williamson Appalachian	0.9237	0.96060	6,927	1,790
Reg. Med. Ctr. Hopkins	1.1564	1.13339	13,136	4,125
Lourdes Hosp.	1.1559	1.14151	12,540	4,929
Western Baptist Hosp.	1.0814	1.15632	12,709	4,334
Kings Daughters Hosp.	1.0488	1.04857	5,780	1,860
Humana Lake Cumberland	1.0544	1.11664	9,090	3,219

LOUISIANA

Opelousas Gen. Hosp.	1.0331	1.12508	6,591	1,832
Lincoln Gen. Hosp.	1.0468	1.09216	6,472	2,581

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MAINE

Kennebec Valley Med.Ctr.	1.1356	1.22267	8,895	2,766
Mid-Maine Med. Ctr.	1.0851	1.19416	9,293	3,313

MICHIGAN

Community Health Ctr.	1.1151	1.12772	4,767	1,853
Gratiot Comm. Hosp.	1.0691	1.07696	6,388	2,272
Alpena Gen. Hosp.	1.0767	1.13528	4,880	2,273
Marquette Gen. Hosp.	1.1952	1.32669	9,315	3,425
Munson Hosp.	1.1029	1.15131	11,065	4,310
Northern Mich. Hosps.	1.2455	1.31546	10,301	4,195

MINNESOTA

St. Joseph's Hosp.	1.0469	1.16061	6,486	2,791
Rice Mem. Hosp.	1.2481	1.33293	6,607	2,690
Immanual/St. Joseph's	1.2065	1.23357	9,800	3,148

MISSISSIPPI

N. Miss. Med Ctr.	1.1006	1.19124	28,617	8,398
Rush Foundation Hosp.	1.0524	1.07633	10,018	2,753
Forrest Gen. Hosp.	1.1223	1.10686	16,727	4,595
F.G. Riley Mem. Hosp.	1.1030	1.08094	6,716	3,247
Delta Med. Ctr.	1.1327	1.16664	6,686	2,044
Methodist Hosp.	1.0384	1.09680	6,967	3,095
Golden Triangle Med. Ctr.	1.0610	1.12864	7,789	2,406
Jeff Anderson Med. Ctr.	1.0117	0.98819	10,300	3,396

MISSOURI

St. Francis Med. Ctr.	1.0691	1.10410	10,548	4,705

MONTANA

St. Patrick Hosp.	1.2624	1.48493	7,404	2,862
St. James Comm. Hosp.	1.1257	1.20057	6,471	2,692
Missoula Comm. Hosp.	1.1120	1.19151	5,956	1,262
Kalispell Reg. Hosp.	1.1045	1.12311	6,013	1,842

NEBRASKA

Good Samaritan Hosp.	1.0884	1.20687	8,710	3,562
St. Francis Med. Ctr.	1.0966	1.14771	6,218	2,076
W. Nebraska Gen. Hosp.	1.1087	1.20568	N/A	3,125

NEW HAMPSHIRE

Mary Hitchcock Mem.	1.2830	1.46990	13,384	3,631
Cheshire Med. Ctr.	0.9955	1.08856	6,518	2,203

NEW MEXICO

Guadalupe Med. Ctr.	1.1152	1.11907	6,013	1,971

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Lea Reg. Hosp.	1.0728	1.08190	6,884	1,527

NEW YORK

Benedictine Hosp.	1.0395	1.06504	N/A	3,241

NORTH CAROLINA

Rutherford Hosp.	1.0840	1.13483	6,489	2,414
Cleveland Mem. Hosp.	1.0842	1.07477	11,202	2,995
Southeastern Gen. Hosp.	1.0648	1.09893	6,303	3,013
Johnston Mem. Hosp.	1.0489	1.09551	4,300	1,234
Albemarle Hosp.	1.1751	1.26903	5,950	2,016
Moore Mem. Hosp.	1.1785	1.23055	12,771	3,980
Wilson Mem. Hosp.	1.1444	1.16852	14,262	4,052
Craven Co. Hosp.	1.1816	1.24841	11,815	3,183
Nash Gen. Hosp.	1.1542	1.21871	12,213	3,223

NORTH DAKOTA

St. Joseph's Hosp.	1.0384	1.09863	4,941	1,810
Trinity Med. Ctr.	1.0324	1.13198	7,267	2,760

OHIO

Scioto Mem. Hosp.	1.0922	1.10072	6,897	2,192
Union Hosp.	1.0599	1.08884	6,892	2,149
Marion Gen. Hosp.	1.1420	1.15606	8,024	1,605
Community Med. Ctr. Hosp.	1.0385	1.12322	4,926	1,084
Good Samaritan Med. Ctr.	1.0541	1.12338	8,674	2,371
Holzer Med. Ctr.	1.1103	1.13588	9,208	2,061
Blanchard Valley Hosp.	1.0778	1.14109	11,807	3,099
E. Liverpool City Hosp.	1.0123	1.10789	7,323	2,414
Ashtabula Gen. Hosp.	1.0204	1.06362	7,627	2,084
Med. Ctr. Hosp.	1.0579	1.08420	9,228	1,698
Cleveland Clinic Hosp.	1.7170	1.85286	31,292	9,903
N. Columbia Co. Hosp.	0.9815	1.08345	9,329	3,238
Betheda Hosp. Assoc.	1.0593	1.14623	10,175	2,216

OKLAHOMA

St. Josephs/Ponca	1.0232	1.11180	6,960	2,189
Jane Phillips Med. Ctr.	1.1010	1.17669	9,286	3,066
Valley View Hosp. Auth.	1.1684	1.16744	5,888	2,234
Jackson Co. Mem. Hosp.	1.0428	1.11024	3,769	2,440
MUskogee Gen. Hosp.	1.0860	1.19656	13,026	4,551
McAlester Gen. Hosp.	0.9989	1.07294	7,674	3,271
Mem. Hosp. S. Okalahoma	1,0382	1.08585	5,805	2,263
Stillwater Med. Ctr.	1.0418	1.14356	6,320	1,905
Grady Mem. Hosp.	1.0847	1.12086	5,150	2,109

OREGON

Good Samaritan Hosp.	1.1252	1.17726	7,687	2,464
St. Charles Med. Ctr.	1.1297	1.17355	9,604	2,948

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Merle West Med. Ctr.	1.1115	1.15078	7,765	2,577
Bay Area Hosp.	1.1491	1.22737	7,395	2,870
PENNSYLVANIA				
Geisinger Med. Ctr.	1.2370	1.36596	18,951	6,764
Jameson Mem. Hosp.	1.0337	1.05295	9,782	3,374
Lewiston Hosp.	1.1129	1.14331	8,192	3,335
Robert Packer Hosp.	1.3475	1.49808	14,274	4,989
Armstong Co. Mem.	1.1224	1.12628	7,523	3,369
Butler Mem. Hosp.	1.0333	1.01800	9,698	4,527
Oil City Hlth. Ctr.	0.9861	1.03539	5,782	2,156
SOUTH CAROLINA				
Orangeburg Reg. Hosp.	1.1248	1.14239	11,813	3,465
Tuomey Hosp.	1.1234	1.16981	9,450	2,524
Self Mem. Hosp.	1.0806	1.15686	11,805	3,648
SOUTH DAKOTA				
Sacred Heart Hosp.	1.0865	1.19735	5,348	2,243
St. Lukes Hosp.	1.1026	1.15200	7,188	2,419
Rapid City Reg. Hosp.	1.0417	1.13267	13,351	4,382
TENNESSEE				
Jackson-Madison Co.	1.0668	1.22309	15,842	9,476
TEXAS				
Sid Peterson Mem.	1.1142	1.20712	5,946	2,650
McCuistion Reg. Med.	1.0728	1.12044	7,856	2,612
St. Josephs Hosp.	1.0508	1.12159	6,227	3,345
Navarro Reg. Hosp.	1.1252	1.15982	6,410	2,961
RHODE ISLAND				
Rutland Hosp.	1.0753	1.16388	10,795	3,631
Putnam Mem.	1.1037	1.12726	6,067	1,951
VIRGINIA				
Rockingham Mem.	1.0915	1.12356	10,761	3,713
Winchester Med. Ctr.	1.1330	1.26781	15,457	4,714
Halifax Comm. Hosp.	1.0418	1.06056	6,840	2,356
Mary Washington	1.0166	1.10955	13,259	4,397
Mem. of Martinsville	1.0894	1.08416	9,079	2,874
WASHINGTON				
St. Mary Med. Ctr.	1.1973	1.25692	5,275	2,029
Skagit Valley Hosp.	1.1275	1.16463	6,771	2,391
Central Washington	1.2329	1.31794	9,254	3,204
St. Johns Hosp.	1.1542	1.23252	6,222	3,057
Olympic Mem. Hosp.	1.0849	1.10635	6,638	2,616

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WEST VIRGINIA

W.Va. Univ. Hosp.	1.1424	1.14946	N/A	4,177
United Hosp. Ctr.	1.1047	1.12815	15,524	5,719
Monongalia Co.Gen.	1.0757	1.13997	10,830	3,927
Fairmont Gen. Hosp.	1.0101	1.06651	N/A	3,867

WISCONSIN

St. Michaels Hosp.	1.1335	1.22106	6,039	2,028
St. Clare Hosp.	1.1222	1.23410	7,089	2,357
St. Josephs Hosp.	1.3166	1.42424	18,638	5,843
St. Agnes Hosp.	1.1205	1.19145	7,919	2,948

N/A indicates the data is not available for total discharges.

Senator Baucus

8. Q. Are you considering any changes to the existing standards for rural referral status as part of the Department's upcoming Medicare regulations next month? What modifications are you considering? What would the effect of these changes be on currently qualified rural referral centers and other hospitals that might qualify for such status?

A. In the regulations to be published in June 1986, we are proposing to raise the case mix index standards by approximately 2.7 percent over existing standards. Available data on claims through the midpoint of FY 1986 show that this is the overall percentage of increase in all Medicare claims compared to FY 1985 levels. The percentage will be updated further when the final regulations are published in September and more current data are available.

We are also proposing to lower the number of discharge standard by 8.05 percent. This percentage of decline is based on the American Hospital Association's panel survey data which show that since 1981, the percentage of admissions to acute general hospitals has declined by 8.05 percent. The new national number will be 5,517.

Since the percentages of change we are proposing to apply to both the case mix index and the number of discharges standards approximate national trends of all acute care hospitals, we do not expect our proposals will have significant impact on either hospitals currently qualified as rural referral centers or on those which are not. That is, unless a hospital has experienced changes in its case mix index or number of discharges which varies significantly from national trends, we would expect those hospitals which qualified as referral centers initially to continue to qualify and those which could not meet the original criteria would continue not to qualify.

American Hospital Association

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August 12, 1986

Edmund Mihalski, C.P.A.
Deputy Chief of Staff
  for Health Policy
Committe on Finance
U.S. Senate
Washington, D.C. 20510

Dear Mr. Mihalski

Please find attached Gordon Russell's responses to questions posed by Senators Durenberger and Packwood during the Finance Committee's hearing on the status of rural hospitals under the Medicare program.

Please accept my apologies for the late response. I appreciate the great lengths to which you have gone to make these answers a part of the hearing record.

Sincerely

Michael J. Rock

Michael J. Rock
Associate Director for Legislation

RESPONSES TO QUESTIONS ON RURAL HOSPITALS

Senator Durenberger

1. Rural Referral Hospitals. The criteria that have been developed by the Department of Health and Human Services for the designation of rural referral centers are intended to identify those hospitals that treat a mix of patients that is significantly different from the mix of patients treated by the "average" rural hospital. The criteria are applied in a rigid manner that inevitably results in the unfair treatment of certain hospitals. For example, several hospitals almost meet the case mix index criterion, missing it by only a few thousandths of a point. Other hospitals report that they would meet the criterion if they dropped a service that in fact makes them a referral hospital, for example, a cancer treatment program. Although these hospitals do not meet the criteria, they do have costs that are substantially higher than the average rural hospital, and would be appropriately compensated using the urban rate. The criteria should be used to create a presumption that a hospital is a referral hospital, but hospitals should also be permitted to present alternative data that demonstrate the inadequacy of payment under the rural rate. It is unreasonable to substitute the mindless application of an arbitrarily derived set of quantitative criteria for what intrinsicly requires considerable judgement.

   An administrative appeals process could be structured that would assign the Secretary the responsibility for determining whether a hospital is in fact serving as a referral hospital even though the hospital fails one of the criteria. Such a procedure would not necessarily open the door to the resolution of disputes through the courts, but would provide an important assurance that the determinations made by the Department are reasonable. Historically the courts have been reluctant to intervene in substantive decisions by the Secretary that are clearly within the scope of his authority. The courts can, and should intervene, if there is evidence that the Secretary abused his discretion. Ultimately, of course, improvements in the DRG system are needed that will enable the system to accurately distinguish among the types of patients admitted to different hospitals and that will enable the arbitrary urban/rural price differential to be eliminated.

2. Alternative Criteria for Referral Hospitals. Several modifications could be made in the criteria for designating a rural referral hospital. One approach is to permit hospitals offering the same type of services as urban hospitals to qualify as referral hospitals, e.g., intensive care units, advanced radiographic services such as CT scanning and Magnetic Resonance Imaging, cardiac catheterization, or programs for the implantation of artificial joints. Another approach, however, is to permit the hospital to exclude certain types of patients who are assigned DRGs that are relatively infrequent in other rural hospitals, but which tend to depress the hospital's case mix index, e.g., oncology patients. Another alternative is to exclude the large urban teaching hospitals from the calculations because these hospitals are significantly different from the average urban hospital.

3. Labor Market Definitions. The current labor market definition should be revised by clustering hospitals that draw employees from the same geographic area. An alternative is to cluster counties in which the prevailing wage level is approximately the same. A third, and simpler alternative, is to join counties that are contiguous with urban counties to the neighboring MSA with the wages that are closest to the average wage in the hospitals located in the "rural" county.

Senator Packwood

1. Financial Performance. There is substantial variation in hospital operating margins within any group of hospitals. Although the patient margin of rural hospitals increased somewhat between 1983 and 1984, the patient margin of small hospitals -- eighty-five percent of which are rural -- declined substantially, from -0.3 percent to -12.5%, while the patient margin of hospitals operating between 25 and 49 beds -- over eighty percent of which are rural -- declined from 3.7 percent in 1983 to 2.2 percent in 1984. In 1985, hospitals operating twenty five or fewer beds continued to experience a twelve percent deficit, while the patient margin of hospitals operating 25 to fifty beds declined to 0.5 percent. In addition, it should be noted that small hospitals (below 50 beds) are much more likely to experience deficits of three percent or greater: over 56% of hospitals operating fewer than fifty beds experienced deficits of this magnitude, compared to just under 35 percent of hospitals operating more than 100 beds. Finally, it should be noted that nearly 30 percent of rural

hospitals experienced deficits of six percent or greater, compared to under 15 percent of urban hospitals, in 1984.

2. Admission Criteria for Rural Referral Hospitals. The hospital industry has had significant problems with the definition of rural referral hospitals since the implementation of the prospective payment system. The number of patients admitted to or discharged from a hospital is, at best, only indirectly related to the hospital's status as a referral center. The central issue is the type of patients admitted to the hospital. If, however, a volume criterion is to be adopted, then it should clearly be adjusted to reflect changes in overall admission patterns. However, it should be noted that a more than 12 percent downward adjustment may be appropriate because the number of admissions has fallen more rapidly in rural hospitals than in urban hospitals, and the critical issue is whether the rural referral hospitals are significantly different from other rural hospitals, not whether they are indistinguishable from their urban counterparts.

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300 south 17th lincoln, nebraska 68508 402/475-2525

Response by

Joyce Jensen
Vice President
National Research Corporation
Lincoln, Nebraska

to Follow-Up Questions by

Senator Durenberger
and
Senator Packwood

United States Senate
Committee on Finance
Subcommittee on Health
Washington, D.C.

June 4, 1986

Answers to Follow-Up Questions from Senator Durenberger

Question: Since the National Research Corporation conducts studies of consumers on a national basis to determine their needs and viewpoints, what has NRC learned about the mental health care needs of Medicare beneficiaries? Do you have any suggestions about how we might formulate a better policy for mental health services?

Response: Medicare beneficiaries in our past studies have not rated mental health services as needed to the extent that they have rated other services. Most Medicare beneficiaries, being in the 65/over age categories, are more apt to have a less than "open" attitude toward mental health services than those of us in younger generations. We just this month will release a new study which asks consumers if they have used mental health services and if they see a need for more services in the community -- I will forward that information to you once it is available.

In response to the second part of your question, time constraints have not allowed me to investigate current policies for mental health services in enough depth to make suggestions.

Question: You indicate that urban hospitals are developing networks of satellite facilities, including physician clinics or ambulatory care centers.

What impact are these satellites having in rural areas? Will they eventually replace rural hospitals?

Response: The satellite facilities are obviously pulling patients away to urban facilities as the physician/patient relationship tends to be especially strong in rural areas. However, if the satellite facilities are using local hospitals for those services not requiring more sophisticated facilities, the satellite facilities are actually having a positive impact in providing high quality care both by using the local hospital when possible and also referring out those cases which cannot and should not be handled there.

I believe the satellite facilities will eventually replace rural hospitals as they once were -- but may actually enhance the facilities if arranged in the rural hospital's favor. If the local hospital is not involved, eventually the satellite facilities could lead to the rural hospital's demise as people will go where their perceived expert suggests, especially the more critical the care needed.

Answer to Follow-Up Question from Senator Packwood

Question: In your opinion, do we need all the rural hospitals that currently exist or is there a better way to serve rural patients?

Response: I believe we need rural hospitals--especially those providing care in areas where access to metropolitan facilities is quite a distance, not just those designated as sole community providers. Perhaps the realignment or reconfiguration of services offered which is occuring as a result of DRG's will result in a rural facility much different that what existing or past rural hospitals have been, providing care to local residents in a mode which can provide more high quality care to the point their expertise goes, and then referring to larger institutions, rather than trying to be "all things to all people."

I see rural hospitals becoming "stabilization points" for critical care, handling routine illnesses and surgeries, and providing ongoing treatment for illnesses such as cancer, as well as those services needed for the greater proportion of the aged living in rural communities.

UNIVERSITY OF MINNESOTA
TWIN CITIES

Center for Health Services Research
420 Delaware Street S.E., Box 729
Minneapolis, Minnesota 55455-0392
(612) 624-6151

June 4, 1986

Shannon Salmon
United States Senate
Committee on Finance
Washington, DC 20510

Dear Ms. Salmon:

I have enclosed answers to the follow-up questions from Senator Durenberger on my testimony on the status of rural hospitals. I would be glad to answer any other questions, if necessary.

Sincerely,

Ira Moscovice

Ira Moscovice, Ph.D.
Associate Professor and
Associate Director

IM:amm

Enclosure

Response to Questions from Senator Durenberger

1. I have not completed any primary research on mental health care in rural areas. However, I can offer some general comments on the issue. First, diagnosis is generally a poor predictor of resource use for mental health problems. Thus, the severity of illness issue and outlier issue are particularly relevant for consideration of mental health problems in a DRG type system. Second, insurance coverage of psychiatric services is very limited in rural areas where many individuals have no insurance coverage or do not have group insurance coverage available. Third, rural areas lack alternatives to hospital care for the treatment of the mentally ill. Current federal and state health policies do not lend optimism to the hope that the increased mental health problems of rural residents will be appropriately addressed. One suggestion would be the development of a joint federal/state program to specifically address these needs through existing rural health professionals and institutions.

2. In my NCHSR study in 1983 I stated that "the development of rural HMO's is often not a practical solution to meet the primary care needs of a rural area." This conclusion was based on the evidence that few successful rural HMO's were operational prior to 1981. This was primarily due to several characteristics of rural areas including an inadequate supply of physicians, financially troubled hospitals, a limited economic base, and sparsely settled populations with firmly entrenched health care seeking patterns. The development of mature competitive markets, in states such as Minnesota, has changed the playing field for rural physicians. At this point in time, many rural physicians are feeling the pressure of competition, from urban-based clinics and HMO's. As a result, they may be facing the decision of having to join a competing clinic/plan or forming

one of their own. There is currently an increased chance for the successful development of rural HMO's, particularly those based on the open panel (IPA) model. This will happen only if rural physicians seize the opportunity to band together to meet the health needs of rural communities.

3. I do not have any data which indicate the financial performance of investor-owned rural hospitals. The Department of Special Studies, American Hospital Association might be one potential source of information on this topic.

Jeffrey C. Merrill
Vice President
Robert Wood Johnson Foundati

Follow-Up Questions from Senator Durenberger

1. In your written testimony, you address the question of depressed rural economies and their impact on a community's ability to support its hospital. The farm crisis and the increasingly eroding tax base which supports rural hospitals is exacerbating the financial difficulty of many of these institutions.

   Given this situation, what solutions do you suggest?

I will have to defer to the Congress and the Administration, who are far more capable than I, in identifying solutions to the farm crisis. I would point out, however, that rural hospitals represent a significant economic force in many rural communities and their survival has a great deal to do with the overall economic health of those areas. The ability of communities to attract industry is often tied to the presence of a hospital. Thus, the survival of a hospital can be very much intertwined with an improved economic situation in that community. Secondly, and more directly, the hospital is often a major employer; thus, the closure of a facility will have a deleterious impact on employment rates. The preservation of hospitals, therefore, extends beyond simply questions of medical care and has to do with the overall physical and economic health of that community.

While solving the farm crisis and the economic plight of rural communities extends beyond either the scope of my knowledge or abilities, there is no question that the plight of rural hospitals is very much intertwined with this broader issue.

2. I understand you are exploring ways to assist rural hospitals throughout the country in achieving financial stability and improving quality. While I know that the work and thinking on this type of program is in its preliminary stages, what can you share with us about its focus?

You are right in your assertion that the Foundation is exploring ways to assist rural hospitals. We are not yet in a position to decide on a specific plan or, indeed, whether we will in fact be able to implement such a program. However, in looking at this issue it appears to us that there are some solutions which may be of help and that the implementation of these solutions (i.e. consultants, start-up funds, equipment purchase, etc.) may not be that expensive. Basically, programs to help rural hospitals must achieve three(3) things:

1. Expand the current revenue base - by this I mean extending the roles of rural hospitals beyond simply the provision of in-patient acute care to a broader range of services, some of which may even be outside of the health field. Hospitals might consider doing this alone or, preferably, in conjunction with other facilities. Such services might involve home health care, out-patient physical therapy, wellness programs, school

health, or such activities as converting capacity into nursing homes or even hotels, into hotels or providing meal services to the larger community.

2. Reducing expenditures - this might take two forms: 1) increasing efficiency through shared purchase arrangements, reducing energy costs, or staffing; or 2) actual reductions in service capacity either through the closure of beds or the elimination of services. As well as a reduction in capacity, improving efficiency might also involve the conversion of existing beds or services to something else where there is a higher return to the institution. An example of this would be the conversion of acute care beds to nursing home beds.

3. The improvement of quality - if rural hospitals are both to survive and provide adequate health care, they must upgrade their quality. Too often, because of the age of the plant or because of the number or level of the medical staff, this is a serious issue. Local individuals may not use their facilities for fear of receiving poor quality care and, thus, seek care elsewhere. Possibly, through affiliations with larger, urban institutions; through greater focusing of service capacity; and through an upgrade of plant and equipment, quality might be improved. This, in turn, will help maintain both a competitive position for the facility and improve the overall quality of health care in that area.

RESPONSE OF WILLIAM BROCKMANN TO FOLLOW-UP QUESTION FROM SENATOR DAVID DURENBERGER

Hearing on Rural Hospitals
Under the Medicare Program

Before the Senate Finance Committee
Subcommittee on Health
May 9, 1986

Q. In your written testimony, you argue that the "6,000 discharge" criterion is arbitrary. What criteria would you establish to designate Rural Referral Centers?

A. We believe that the Rural Referral Center regulations should accurately reflect Congressional intent and the purpose underlying the governing legislation. In §2311(a) of Public Law 98-396, Congress recognized that certain rural hospitals with fewer than 500 beds may provide more sophisticated services than typical small rural hospitals and therefore should be reimbursed at a higher rate. Accordingly, Congress provided that a hospital which is classified as a rural hospital may apply to be reclassified as a Rural Referral Center, by reason of certain of its "operating characteristics" being similar to those of a typical urban hospital located in the same census region. Congress specifically provided that such operating characteristics may include "wages, scope of services, service area, and the mix of medical specialties." Significantly, neither the authorizing legislation nor the legislative history suggests or implies that the number of discharges should be used as a criterion for identifying Rural Referral Centers. Accordingly, no "discharge" criterion should be included in the implementing regulations.

We believe that, if the mandatory "number of discharges" criterion were eliminated, the other criteria included in the current regulations would adequately identify hospitals entitled to the Rural Referral Center designation. A Rural Referral Center is distinguished from a typical community hospital by its technical sophistication and complexity of services. These attributes are reflected in such factors as the hospital's case-mix index, the range of medical specialties represented on the medical staff, the scope of services offered, the number of referrals from physicians not on the medical staff, and the distances travelled by patients. All of these criteria are already incorporated into the current regulations.

Specifically, under the current regulations even if the discharges criterion were eliminated, a rural hospital would be required to meet the same median case-mix index as urban hospitals in its census region. HCFA has recognized that the case-mix index reflects the scope of services and the mix of medical specialties -- two of the most important "operating characteristics" required to be considered under the governing legislation. Therefore, any rural hospital which meets the median case-mix requirement provides the scope and range of services provided by larger urban institutions and incurs costs atypical for rural hospitals.

In addition, however, in order to be entitled to Rural Referral Center status, a rural hospital must meet at least one of three additional optional criteria: (1) at least 50% of its medical staff must be specialists who are either Board certified or Board eligible; (2) at least 40% of its patients must be referrals from physicians not on the medical staff; or (3) at least 60% of its discharges must be of patients residing more than 25 miles from the hospital.

We believe that these criteria adequately identify those hospitals entitled to Rural Referral Center designation, and that, therefore, the "discharges" criterion is superfluous and serves only to prevent rural hospitals which are providing sophisticated services from receiving the fair and adequate compensation which they need to continue to offer specialty care.

If, however, if it is determined that a hospital's number of discharges should be considered in determining the hospital's entitlement to Rural Referral Center status, a number of alternatives are available:

- The number of discharges could be used as an "optional" rather than a "mandatory" criterion. Under current regulations a hospital must meet both the "number of discharges" and the case-mix criteria, along with one of three optional criteria. As discussed above, by far the most important criterion is the "case-mix" criterion. If a rural hospital meets this criterion, it has demonstrated that it provides essentially the same range and sophistication of services provided by larger urban hospitals. Accordingly, the regulations could be modified such that the case-mix criterion is the sole mandatory criterion and the "discharge" criterion could be retained as an optional, rather than a mandatory, standard.

- The "discharges" criterion could be retained as an "optional" criterion, and the "medical specialists" standard could be used as a "mandatory" criterion. As discussed above, the purpose of the Rural Referral Center criterion is to identify rural hospitals which provide more sophisticated services and a wider range of services, than the typical small rural hospital. Discharges clearly are not an accurate measure of these characteristics. The range of medical specialists represented on a hospital's full-time medical staff, however, is an appropriate measure of the range of services provided by the hospital, and, accordingly, we believe that it would be appropriate to upgrade the criterion relating to the medical staff to a "mandatory" criterion, while making the "discharge" criterion optional. In our view, such a change would result in criteria which more accurately reflect the purposes underlying the Rural Referral Center regulations.

* If the "discharges" criterion is to be maintained as a mandatory criterion, hospitals currently designated as Rural Referral Centers should be grandfathered. As explained at some length in the testimony of Caylor-Nickel Hospital, rural hospitals which have been already designated as Rural Referral Centers continue to provide the same range of services and specialized care in the same rural area; however, due to a combination of factors unrelated to the sophistication of the care provided or the range of services offered, the number of discharges for Rural Referral Centers has dropped. Reductions are due, in varying degrees, to the general effects of the prospective payment system, advances in medical technology which reduce the necessity of inpatient care, and depression in the rural economy causing loss of income and population in rural areas. Because these factors do not affect the range of services or the sophistication of services provided by hospitals which have already qualified as Rural Referral Centers, Congress should recognize that so long as such Rural Referral Centers continue to meet other relevant criteria, they should be permitted to maintain their Rural Referral Center designation.

We respectfully submit that any of the foregoing options would be preferable to retaining the current "discharges" requirement. This criterion, as currently applied, precludes rural hospitals entitled to Rural Referral Center status from being reimbursed for the more sophisticated and wider range of services which they provide to their communities in outlying areas. Hospitals which can demonstrate that, in fact, they provide a wide range of secondary and tertiary services should not be deprived of the payment they need to continue to provide these services to rural America.

The Billings Clinic

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IMMEDIATE CARE
Gene V. Holden, M.D.
John J. Fina, M.D.
INTERNAL MEDICINE
Allan Lee Goulding, M.D., P.C.
George P. Brown, M.D.
Paul V. Hoyer, M.D.
Lucinda M. Husby, M.D.
Heights Office-Barry M. Hochstadt, M.D.
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John R. Burg, M.D.
Herman D. Sommers, M.D.
Richard P. Ulrich, M.D.
ENDOCRINOLOGY
Martin E. Rodish, M.D.
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Wilderness and Mountain Medicine
Donald I. Twito, M.D.
INFECTIOUS DISEASES
Ronald H. Smith, M.D.
NEPHROLOGY
Donald L. Hicks, M.D.
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PULMONARY AND
CRITICAL CARE MEDICINE
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John W. Heizer, M.D.
ADMINISTRATOR
Steven E. Roger

M8000

May 27, 1986

United State Senate
Committee on Finance
Attention: Shannon Salmon
Washingston, D.C. 20510

Dear Ms. Salmon:

This is in response to your letter of May 15,1986.

1. No. In fact it has improved recently. The second part of question #1 does not apply. The third part - yes. In particular situations where a community loses it's only physician or there is a reduction in the number of physicians occurring in that community. Occasionally a specialist will leave a community, thus losing the expertise in health care previously supplied. The main reason for a specialist leaving a small community is usually related to the cost of liability insurance.

2. This is certainly possible. You could label this as "diagnosis creep". In Montana and Wyoming it is not recognized as a major problem and so far very few denials have been made by the PRO.

The Billings Clinic Downtown
2825 8th Avenue North
P.O. Box 35100
Billings, MT 59107-5100
(406) 256-2500

Heights Family Medical Care Center
100 Wicks Lane
P.O. Box 35104
Billings, MT 59107-5104
(406) 252-8287

Red Lodge Clinic
10 South Oaks
P.O. Box 1120
Red Lodge, MT 59068
(406) 446-2412

ACCREDITED BY ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE, INC.

There is a definite need for a DGR for "social" admissions. If this were budget neutral to the hospital, it would eliminate any tendency to abuse.

As for the criteria distinguishing the appropriateness of a "social" admission, this would not be a problem for AMPRA to develop. The criteria would have to be very flexible and must rely largely on the attending physician's judgment. The attending physician should be required to document on the chart the number of "social" days and the reason why.

I would strongly recommend another category DGR -- again budget neutral. This would apply when a patient reaches the outlier status in the small rural hospital, either in length of stay or financial.

Sincerely,

STERLING R. HAYWARD,M.D.

mjs

Follow-Up Questions from Senator Durenberger for Sterling Hayward, M.D.

1. As a member of a medical peer review organization, but also as a physician who has practiced medicine in the Wyoming-Montana region, have you detected a decline in the quality of medical care delivered to patients in rural hospitals?

   If you have noted such changes, what type of patient is most at risk? To what do you attribute this decline?

   Lastly, do you feel that it is now more difficult for some rural residents to obtain medical care in their communities?

2. In your written testimony you very effectively explained how a lack of alternative services in a rural community puts pressure on doctors to admit patients to hospitals or to keep them there longer. You state that this results in attempts to justify admissions on insupportable grounds, putting the hospital at risk to PRO review. As a solution, you advocate establishing a "social" DRG which would permit a low level of reimbursement to cover these instances.

I understand the dilemma you have outlined, but my concern is that the criteria for specifying what a "social" admission is would be nebulous and subject to abuse. How would you define the criteria so that physicians, hospitals, and ultimately PROs can appropriately distinguish between a justified social admission and one which is not justified.

(C0543)

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United States Senate

COMMITTEE ON FINANCE
WASHINGTON, DC 20510

May 15, 1986

Eugene C. Beck
Director, Office of Rural Health
Intermountain Health Care, Incorporated
36 South State Street
22nd Floor
Salt Lake City, Utah 84111

Dear Mr. Beck:

To follow-up on your testimony at the May 9, 1986 Subcommittee on Health hearing on the status of rural hospitals under the Medicare program, Senator Durenberger would like you to answer the attached questions.

Your response should be typed on letter-size paper and double spaced. To meet our printing schedule, please provide your answer no later than June 6, 1986. Send the response to:

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, D.C. 20510

If you have any questions, Ms. Salmon may be reached at 202/224-4515.

Sincerely,

EDMUND J. MIHALSKI, C.P.A.
Deputy Chief of Staff
for Health Policy

Follow-Up Questions from Senator Durenberger for Eugene C. Beck

1. This Committee is interested in innovative solutions to the problems of providing health care in sparsely settled, rural areas. Would you provide a brief account of the network of satellite facilities Intermountain is developing, including physician clinics or ambulatory care centers.

   What impact are these satellites having in rural areas? Do you expect this kind of satellite approach to eventually replace rural hospitals in Western States? In all States?

2. I understand that LDS Hospital operates a helicopter and fixed wing medical evacuation service. How does that fit in with serving rural areas and your system of linked hospitals?

3. To what extent do you believe a medical evacuation network can be used to provide remote areas with access to hospital care?

(C0557)

1. **This Committee is interested in innovative solutions to the problems of providing health care in sparsely settled, rural areas. Would you provide a brief account of the network of satellite facilities Intermountain is developing, including physician clinics or ambulatory care centers.**

Intermountain Health Care is working from a strategy that provides for both horizontal and vertical integration within a given geographical catchment area (market service area). The system of satellite facilities - clinics and ambulatory care centers - is located in a radiating hub and spoke concept from the rural hospital into the extremely remote communities of Utah, Idaho and Wyoming.

What impact are these satellites having in rural areas? Do you expect this kind of satellite approach to eventually replace rural hospitals in Western States? In all States?

The impact that these satellite facilities are having is in providing a key access area for basic primary services. These services are having a difficult time to economically justify their own existence. However, the network that they provide will help assure flow of patients into the system's hospitals. I do not expect this approach to eventually replace rural hospitals. Their function and the services they provide will continue to change as new definitions of appropriate levels of services are determined.

Geisinger

Geisinger Foundation
Response to Questions by
Subcommittee on Health
Committee on Finance
United States Senate

"RURAL HOSPITALS UNDER THE MEDICARE PROGRAM"

Presented by
Frank J. Trembulak
Senior Vice President and Treasurer

June 6, 1986

Geisinger Foundation
Danville, Pennsylvania 17822
(717) 271-6461

Geisinger Foundation
Response to Questions by
Subcommittee on Health
Committee on Finance
United States Senate

"RURAL HOSPITALS UNDER THE MEDICARE PROGRAM"

Presented by
Frank J. Trembulak
Senior Vice President and Treasurer

June 6, 1986

Geisinger has been requested and is pleased to respond to several questions resulting from our May 9, 1986 testimony before the Senate Subcommittee on Health concerning "Rural Hospitals Under the Medicare Program". This presentation sets forth each of the questions forwarded by Mr. Edmund J. Mihalski, CPA, Deputy Chief of Staff for Health Policy, in his May 15, 1986 correspondence which are followed by our individual responses.

QUESTION: Would you provide a brief account of the factors which were weighed and the options considered during the planning and development of the array of facilities and services now contained in the Geisinger system?

RESPONSE: From inception, Geisinger's founder set forth the organization's role as providing services to the people throughout the Northcentral and Northeastern region of Pennsylvania. Therefore, we welcomed the 1978 challenge from the Pennsylvania Secretary of Health to actively develop a regional system of quality health care as a condition of approving a major facility expansion. Geisinger has responded to regional need by establishing facilities in over 30 communities within our service area. As we entered this phase of rural regional system evolution, many issues influenced our planning and development process. Some of these issues were:

- Our service area, although having certain areas of significant population density, is for the most part comprised of many underserved rural towns and villages linked by narrow winding secondary roadways which weave their way through the countryside.
- Approximately 70% of the Geisinger Medical Center's patients are self-referred, traveling an average distance of 50 miles to receive services in Danville.
- There are many smaller community hospitals throughout our region with varying capabilities, quality, equipment/technology, financial resources and medical staff expertise. Community pride and association with their respective hospital runs deep for in many of these locations the hospital represents a significant, if not the largest, employer and economic influence.
- The rural community hospitals are very competitive in seeking to represent being a full service health care provider. Additionally, each provider is protective of their local health care delivery.
- Historically, the local community providers and physicians have always referred patients to Geisinger for tertiary care services. However, the providers and physicians were and are concerned about closer affiliation with Geisinger for fear of losing their autonomy.
- The local dedication to quality of primary and secondary care is very good. However, many of the local delivery systems lack coordination and are frequently inappropriately controlled by covetous physicians.

- The Prospective Payment System has negatively impacted the small rural providers by both reducing patient volume and the economic return necessary to maintain viable and effective operations.

When considering the foregoing factors in conjunction with our strengths in physician services, management and tertiary care services, pursuing an integrated regional system of health care comprised of the following components seemed most appropriate.

- Take Geisinger quality care to the patient communities by developing a network of physician office practices built around a series of multispecialty group practices ranging in size from 20 to 50 physicians, each with a cluster of remote satellite physician offices of one to five practitioners.
- The remote physician satellite offices provide primary and some secondary care referring patients as needed to the larger multispecialty group practice and in turn, if required, to the Geisinger Medical Center for tertiary care. In essence, it is important to place the primary and secondary care into the community with a tertiary care physician service element located within reasonable proximity and the sophisticated physician and hospital tertiary care technology amassed at the Geisinger Medical Center in Danville.
- The physician practice network is being developed by organizing existing local quality physician practices into group models. If not practical to arrange such local physician amalgamations, we supplement the local physicians with others we recruit or develop the office practice de novo.

- Our physician network functions proactively with all local hospital providers and their medical staffs. We attempt to enhance and support the coordination and quality of the local health care delivery system, both clinically and managerially, by being able to provide backup support as necessa
- We investigated the ramifications of the significant number of tertiary transfers received by the Geisinger Medical Center. We found the burden of such transfer activity fell on the local rural ambulance services. Frequently a community was being left unserved while its sole ambulance transported a critically injured or ill patient to the Geisinger Medical Center. The significant rural regional distances involved, patients not being transferred due to lack of transport resources, and the critical time consumed in such transfers (with patients inappropriately attended while in transit), weighed heavily in Geisinger's evaluation to develop a helicopter critical care rapid response program ("Life Flight"). This program is supported at an economic loss as part of our regional commitment.
- In an attempt to provide more medical and surgical services on an outpatient basis, we were faced with the dilemma of distance for the elderly patients and those requiring next day observation/follow-up. Being unsuccessful in having the fiscal intermediaries support and accept payment for overnight ambulatory accommodations, Geisinger developed, with significant community support, a Ronald McDonald House and an adult facility known as the "House of Care". These pilot programs have been extremely successful in meeting the needs of patients receiving outpatient services and are at risk in making the long trip home and back for follow-up care. Also, the physician network makes available more sophisticated

outpatient services convenient to the patients' homes, thus, eliminating risky long distance travel.

- In an additional attempt to support the local community providers, we developed and marketed a full range of both clinical and managerial health care services as full service or fee-for-service contracts. Typically, we require all elements of the local provider, i.e. administration, medical staff and Board of Directors, to concur and accept whatever involvement we are being asked to provide.
- We promote and sponsor educational programs for the communities, local provider Board members, physicians and media as it relates to various health care issues covering such topics as governance, medical staff bylaws, cost of technology, quality of care, and capital financing.
- Geisinger is committed to support and enhance, not compete with, local health care delivery systems. In that regard, we have not diversified into competitive business lines solely for economic gain but rather work to assist providers, physicians and allied health services to improve and complement their operations. Only if we deem such services inadequate or their quality of care irreversibly unacceptable, do we pursue direct delivery involvement.

Generally, we find the more informed and progressive local providers and physicians seeking out and requesting our services and other relationships.

QUESTION: How does the Geisinger system differ from other medical networks operating in rural areas?

RESPONSE: Geisinger differs significantly from other rural medical networks, primarily for the following reasons:

- Geisinger, although comprised of various types of facilities and services, is primarily a physician organization, the core of which is a multispecialty group practice of over 345 full-time salaried physicians. The group practice model provides the professional interaction, stimulus, and availability of consultative support which allows for the continuing enhancement of our clinical program. Additionally, the group practice model allows the remote satellite physician practice access to this same professional interaction and backup support as needed.
- Geisinger actively pursues a triple mission of patient care, education and research which was established from its inception. The organizational commitments to research and education are substantial, for these programs are not supplemental but rather integral parts of our overall comprehensive clinical activity. Naturally, the research and educational programs also enhance the professional environment, providing stimulus and opportunity not typically found in a rural environment and add to our professional recruitment abilities.
- Geisinger's approach has been to amass the sophisticated physician and provider technology in its rural referral tertiary care center as the hub of our delivery system while distributing quality physician care into the rural communities within our service area. This networking and coordination provides a significant integration of primary, secondary and tertiary care. It appears that most other rural medical networks are provider based with numerous local community hospitals functioning in a less integrated and perhaps more competitive fashion.

- Geisinger's integrated health care system provides for a high volume of clinical activity/material necessary to maintain physician proficiency and justify the costs of new technology.

QUESTION: To what extent do the problems of the rural East differ from those of the rural West?

RESPONSE: Many of the problems facing rural providers are the same regardless of location. Some of these problems include the following:

- Most rural service areas are characterized by an aged population and economically depressed regions with high unemployment.
- The recruitment and retention of physicians and specially skilled technicians and competent administrative/managerial personnel is extremely difficult especially when having to compete for these professional positions in a national market with urban centers.
- The significant distances patients must travel without the benefit of public transportation hampers the transitioning of services from an inpatient to outpatient setting. Those services which technically could be accomplished in an outpatient setting but require next day follow-up do not make it medically efficacious to have patients traveling home and then back to the provider for such care. Providing outpatient services on an inpatient basis even under such extenuating circumstances is neither accepted nor paid for by the Medicare Program. This payment policy thus adversely discriminates against the rural provider and beneficiary.
- The availability of eligible physicians readily accessible to patients in order to comply with second surgical opinion requirements of the Medicare program. The restrictions governing physician eligibility for providing a second opinion impose

a difficult burden since physicians in rural areas are often "affiliated" with each other and thus ineligible to provide a second opinion.

- Rural providers frequently must pay premiums for service contracts on sophisticated medical equipment and technology based solely on their location.
- Low clinical volumes adversely affect physician proficiency and the ability of the rural provider to justify the cost of sophisticated technology.
- The current Prospective Payment System and other proposed legislative and regulatory amendments thereto unfairly and illogically discriminate against all rural providers as compared to urban providers by failing to take into account the unique problems facing rural health care providers.

The foregoing examples of rural provider problems are tremendously affected by the rural West's sparsely populated, vast geographical areas. Additionally, the rural Western health care system is comprised for the most part of small, local, unrelated, unaffiliated and significantly dispersed community providers. These two demographic variables are the most significant difference between rural East and rural West health care delivery problems, as the degree to which these two conditions exist proportionately affect and amplify problems as previously stated. Under extreme conditions, these two elements in and of themselves become the most difficult problems to be addressed in the rural West.

An additional item of interest to the Subcommittee appears to be the topic of a uniform or single hospital payment system regardless of provider location. Geisinger would support a single rate hospital payment system for the reimbursement of clinical care if it incorporated an appropriate measurement for the severity of illness. Indigent care could be established on a uniform reimbursement basis which in turn would be multiplied out based on individual provider volumes. However, capital and educational costs would need to be dealt with separately from either the clinical or indigent care components.

We would be pleased to respond to any additional questions the Committee may have or to provide additional information as requested.

GPHA
Great Plains Health Alliance

P.O. Box 366
Phillipsburg, Kansas 67661
(913) 543-2111

June 5, 1986

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, D.C. 20510

Dear Ms. Salmon:

Enclosed are the answers to the questions developed from my testimony on May 9, 1986.

Sincerely,

GREAT PLAINS HEALTH ALLIANCE

Curtis C. Erickson
Curtis C. Erickson
President & CEO

anl

Enclosure

Answers to follow up questions from Senator Durenberger for Curtis C. Erickson.

1. In your written testimony you assert that , "It is imperative to maintain small hospitals if access to quality primary care (in rural areas) is to be preserved." Later, you state that rural communities would be receptive to demonstration projects to address primary care alternatives. Does this indicate a willingness on your part and others to contemplate having entities other than hospitals as sources of health care, or should we concentrate all efforts on hospitals alone?

ANSWER:

Our organization operates 25 rural hospitals in Kansas and one in Nebraska, all of them having less than 50 acute beds. In almost half of these facilities, we have long term care units which are attached as distinct part units and also we provide swing beds (skilled nursing care) as part of the acute hospital. In some of the facilities, we also provide home health, clinic management, perform the public health for the community, and provide school nursing, etc. It is our conviction that in many of these rural areas even further changes will have to be made in the pattern of services of these facilities even to the discontinuance of acute care. This facility might offer emergency services, lab, x-ray and the other diversified services which I have mentioned above that are necessary to meet the communities needs.

We would be very interested in and do indicate our willingness to attempt demonstration projects to address these primary care problems in rural areas of Kansas and Nebraska.

2. Regarding rural referral centers, should the Secretary of HHS be required to adjust downward the 6,000 discharges criteria consistent with the average decline in admissions which has occurred since PPS implementation? Or, would other criteria be more appropriate?

ANSWER:

I believe the Secretary of HHS should adjust downward the 6,000 discharges criteria for the rural referral centers; although I do not have any data to substantiate a certain number. The changes under the Consolidated Omnibus Budget Reconciliation Act of 1985 used 3,000 discharges per year. This certainly would seem more appropriate particularly for the type of facility I discussed in my testimony which serves an area in which there is a population density of 10 people per square mile.

THE HEALTH CENTRAL CORPORATION

THE HEALTH CENTRAL SYSTEM
2810 Fifty-Seventh Avenue North • Minneapolis MN 55430-2496
612/574-7800

May 23, 1986

United States Senate
Committee on Finance
Attention: Shannon Salmon
Washington, D.C. 20510

Dear Ms Salmon:

Attached are my answers for the Senate Finance Committee as a follow-up to the hearing that was held regarding rural hospitals and the PPS system. I hope these will be helpful to you.

Sincerely,

Carol J. Kiecker

Carol J. Kiecker
Regional Vice President

Attachment (1)

CJK:kmw

Follow-Up Questions from Senator Durenberger for Carol Kiecker

1) During the hearing you stated that rural hospitals suffer from Medicare reimbursement rates which are lower than those for urban hospitals. While I concur that the evidence seems clear that PPS has fallen disproportionately harder on small hospitals in rural communities, I would like to ask a basic question: Would the elimination of the urban/rural payment differences ensure the continued survival of small, rural hospitals?

Answer

Certainly the elimination of the urban/rural payment differences would not ensure the continued survival of all small rural hospitals. Nor do I feel that all small rural hospitals need to survive to continue the fine provision of health care services in the rural areas in our country. Certainly many of the difficulties stem from changes in practice of utilization of inpatient acute care services, the shift to ambulatory settings, HMO influences, PSRO outcomes, etc. However, this urban/rural payment difference is so far reaching and is so weakening hospitals that have been strong focal points in the rural areas that I think the system is endangered. Therefore, I would say that the elimination of the urban/rural payment difference will ensure the continued survival of the necessary network of hospitals (but not all hospitals), all other circumstances being equal.

2) There has been some discussion today of alternatives to hospitals in rural areas. Do you think that there are, indeed, viable alternatives? Would anything less than a hospital place rural residents at too great a risk?

Answer

I do believe there are viable alternatives to hospitals in rural areas. These would be/could be ambulatory care centers that perhaps could provide emergency care, lab, x-ray and outpatient services, health promotion, services for the elderly, outpatient surgical services, etc. Some of the difficulties in converting to such a system are simply inherent in the emotional nature of that conversion. On the other hand, the government could be of help in cases where there is long term debt outstanding that simply couldn't be paid for by this decreased intensity service--it would simply not generate enough revenue. This places the local governing boards in a bind since they probably have influenced their friends and neighbors to buy some bonds in the past to support the local hospital. As Medicare develops its capital reimbursement system, perhaps a certain pool of dollars could be made available in certain selected cases to pay off some of these bonds so that barrier could be removed and those appropriate institutions could be converted to a community ambulatory health center. Some grant money for piloting these programs

2) Answer continued

might also be helpful. Certainly multi-hospital systems will attempt to develop some of these alternatives along with their physicians.

The risk question depends largely on distances involved. In sparsely populated areas it probably is very important to maintain hospitals that are truly hospitals. It is difficult to have an intensive level emergency room that is viable without the rest of the expertise and backup systems that come with an acute inpatient facility. The high risks of the agricultural, mining and lumbering industries certainly need to be taken into consideration here.

But in the case where there are other hospitals nearby (note question 1--and the importance of focal hospitals in the rural areas), I believe these ambulatory centers could provide the health care necessary.

Positive incentives for these appropriate conversions from the federal government would be very helpful. These would largely have to do with paying off outstanding debt and grants or loans for conversion money.

I hope these answers have been helpful.

February 2, 1985

MEMORANDUM.....

TO:

FROM: Ronald L. Purdum, President
Albany General Hospital

SUBJECT: SITUATION SUMMARY
RE: MY LETTER OF JANUARY 16, 1985

I offer this memorandum and its attachment as further illustration of Albany General Hospital's situation, and as support for the need to change our Hospital's reimbursement rate.

The attachment provides additional information about our Hospital in comparison to other hospitals in Oregon and across the nation. It also illustrates how this Hospital has responded to what is becoming national health policy relating to utilization of hospitals' inpatient versus outpatient, and the desire to improve productivity in our hospital system.

Albany General Hospital, with a medical staff of 60% specialists; a case mix index equal to or greater than neighboring hospitals; with the lowest cost per stay; the highest percentage of outpatient services; paying wage rates and other costs essentially the same; with levels of service almost identical; finds itself being reimbursed approximately 30% less for the same case than in the neighboring hospitals. Those other hospitals are our competitors. We cannot compete, over the long term, if our end of the playing field is consistently low and theirs is consistently high. I relish the business opportunity to compete and I can't believe that Congress intends that I do so in such an obviously distorted system.

While this problem may have ramifications for other hospitals or other states, my concern is for Albany General Hospital only, and I seek relief for our relatively unique situation.

I will provide you with any information that we have available on Albany General Hospital in support of our request, or for substantiating our particular situation. I will make myself available to your office, your staff, your committees, and to the Executive Branch, at your convenience.

Your assistance is greatly appreciated.

ALBANY GENERAL HOSPITAL COMPARED TO HOSPITALS IN STATE, NATIONAL AND RURAL-URBAN

SOURCE: HAS/MONITREND
November 1984

		Group Medians - Three Month Average			
Select Indicator	AGH	National	State of Oregon	Special Rural	State of Oregon
	3 month average	100-149 Beds 193 Hospitals	100-199 Beds 15 Hospitals	100-169 Beds 90 Hospitals	All Bed Sizes 60 Hospitals
Aver. Length of Stay	4.55	5.28	4.40	5.27	4.25
FTE/ADJ Occupied Bed	3.63	3.88	4.31	3.96	4.54
Inpt Rev/Patient Day	570.21	474.02	606.68	463.72	632.50
Inpt. Rev./Stay	2592.55	2552.32	2828.45	2515.12	2725.57
Exp/Adj Discharge	1945.87	2073.22	2151.22	1983.05	2135.04
Outpatient Revenue %	26.84	17.90	18.51	17.92	21.15

OTHER PONDER POINTS	Fiscal Year End - September 30			
	1980	1983	1984	Current Year To Date (3 months)
Medicare Reimbursement Rate (As % of Inpatient Charges)		79%	82.2%	
Outpatient Surgery % of Total		45%	46%	52%
Delivery In/Out 8 Hours or Less			13%	
Outpatient Revenue as % of Total		25%	28%	
F.T.E.'s Employed	310		252	

SUMMARY

The Revenue Deficit and its Implications:

1. During the 1985 federal fiscal year (FY85), Albany General Hospital (AGH) will be paid only 75 to 80 percent of the DRG payment received by hospitals in the nearby Metropolitan Statistical Areas (MSA) for the same patient illnesses.

2. However, AGH is faced with unit resource costs, such as hourly wage rates, that are equal to or above the mid-range of the MSA hospitals. Also, Albany General's Medicare case mix index, which reflects average patient acuity of illness, is greater than 7 of the 9 MSA facilities.

3. In effect, the federal "urban"/"rural" rate differential results in a projected revenue deficit for AGH in FY85 ranging between about $490,000 and $670,000. This represents the difference between the estimated actual Medicare revenue to be received by AGH versus the amount that would be paid to hospitals in the MSAs for exactly the same patients.

4. To make up for the revenue deficit, AGH must shift Medicare costs to other payors and/or provide comparatively lower levels of patient care than its counterparts in the nearby MSAs; the deficit is far too great to be offset by improved efficiency alone (the hospital is already relatively efficient.)

5. Ultimately, because of the Medicare "urban"/"rural" rate differential, Albany General Hospital will be forced to provide a lower standard of care to its patients than will be available in hospitals located in the nearby MSAs (for the same illneses).

The "Urban"/"Rural" Fallacy -

1. The main purpose of the federal Prospective Payment System (PPS) is to limit Medicare costs by providing hospitals with incentives to become more efficient.

2. The basic concept of PPS is to provide all hospitals with equivalent payments for the same kinds of patients. In theory, the less efficient hospitals (i. e., those whose costs exceed the Medicare rates) either will reduce their costs or go out of business.

3. PPS recognizes that all hospitals do not face the same resource costs; the "urban"/"rural" DRG rate differen-

tial is intended to provide equivalent Medicare payments taking account of these varying resource costs.

4. This basic concept is sound: namely that, everything else being equal, hospitals faced with higher resource costs need larger Medicare payments to provide equivalent patient care. The problem lies with the method being used to implement the program.

5. The Health Care Financing Administration (HCFA) calculated historical Medicare costs and found that the average cost per patient was significantly higher for hospitals located in MSAs than for those outside MSAs, even after adjusting for case mix differences (i. e., HCFA attempted to compare costs for the same types of patients). HCFA established DRG rates based on the average historical costs per patient for MSA and non-MSA hospitals, adjusted for inflation. The presumption (unproven) was that these average cost differences reflect resource cost variations between "urban" and "rural" areas, such as higher wage rates in the cities. (If their greater costs imply lower efficiency, then paying higher rates to the MSA hospitals would be directly contrary to the purpose of PPS.)

6. The reason why the HCFA method breaks down is as follows: Metropolitan Statistical Areas were defined for purposes of counting population and reporting demographic data (U. S. Census). MSA boundaries follow county lines and usually contain large rural areas and many small towns (in Oregon, at least). Having been established for entirely different purposes, one should not expect MSA boundaries to bear a consistent relationship to the resource costs incurred by individual hospitals. In fact, they do not. (If two hospitals are in similar adjacent cities on either side of a county line that also happens to be a MSA border, is it logical to expect that nurses' salaries will be a lot higher on the MSA side?) Moreover, the HCFA calculations identified averages over large multi-state areas and did not provide for the fact that there are large deviations from the averages, in terms of the resource costs faced by individual hospitals.

7. Since we are fortunate to have good data on hospital wage rates and other costs in Oregon, it is easy to show that many of the so-called rural hospitals face higher resource costs than do many so-called urban hospitals. The large differences in base DRG rates represent an undeserved windfall profit for the hospitals that happen to lie within MSA boundaries but have relatively low resource costs, and a large windfall loss for hospitals like AGH that face high resource costs but are not located in an MSA.

8. Thus, there is no rational relationship between the method chosen by HCFA to establish base DRG rates for "urban" and "rural" areas and the basic purpose of the Medicare Prospective Payment System. In fact, the rates are directly contrary to this basic purpose in many cases. They reward inefficient hospitals that have relatively low resource costs but happen to lie in MSAs and they penalize efficient providers like Albany General Hospital that have high resource costs but are not located in an MSA.

The data to support the above statements are contained in the attached exhibits. Each exhibit is preceded by a brief description of its contents and salient points.

EXHIBIT 1 HIGHLIGHTS

Title - Area Map

Contents - The highlighted area contains the following central western Oregon counties: Salem MSA - Marion and Polk; Eugene-Springfield MSA - Lane; area in-between (includes Albany General Hospital) - Linn and Benton. The cities identified on the map are hospital locations.

Observations - The driving distance along Interstate 5 from Salem in the north to Eugene in the south is 64 miles. Albany is about one-third of the distance from Salem to Eugene. It is approximately 8 miles south of the Salem MSA boundary and 30 miles north of the Eugene-Springfield MSA boundary. The area population as of July 1, 1983 was officially estimated at 675,800 (Salem MSA, 250,450; Linn and Benton Counties, 157,450; Eugene-Springfield MSA, 267,900). The large majority of this population is concentrated within a few miles of the Interstate highway which bisects the area from north to south. Government, agriculture, and forest products are the principal employers. Salem is the State capitol. There are major State universities in Corvallis and Eugene, as well as several smaller colleges and universities in scattered cities in the area.

The distance along I-5 from the northern border of Clark County (Washington) to the southern border of Lane County (Oregon) is about 180 miles. Of this distance, only the 38 mile stretch between Marion and Lane Counties lies outside an MSA.

Exhibit 1

AREA MAP

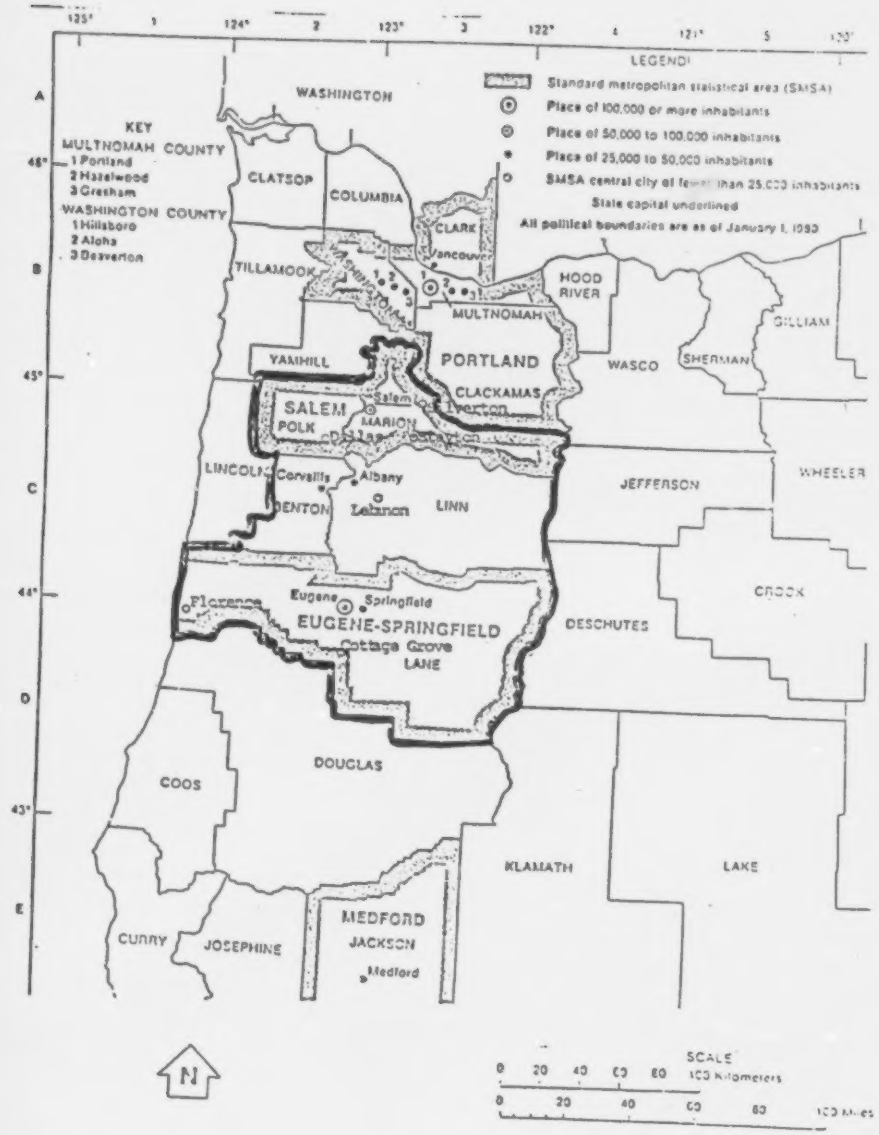

EXHIBIT 2 HIGHLIGHTS

Title - Area Hospitals

Contents - The exhibit lists the hospitals, bed capacities, location and city population for Linn and Benton Counties and the adjacent Metropolitan Statistical areas. (Albany General is in Linn County.) Bed/population ratios are also provided.

Observations - Most of the MSA hospitals have lower bed capacity and/or are located in smaller communities than the non-MSA hospitals, including Albany General. Use of the MSA borders to distinguish urban and rural hospitals does not accurately describe many of these hospital communities.

Exhibit 2

AREA HOSPITALS

HOSPITAL	BED CAPACITY	CITY/COUNTY	CITY POPULATION
Salem MSA:			
Salem Hospital	434	Salem/Marion	90,720
Santiam Memorial	40	Stayton/Marion	4,615
Silverton Hospital	38	Silverton	5,180
Valley Community	44	Dallas/Polk	8,640
MSA Total: beds = 556; population = 250,450; beds per 1000 population = 2.22			
Eugene-Springfield MSA:			
Cottage Grove	35	Cottage Grove/Lane	7,090
Eugene Hospital	57	Eugene/Lane	103,100
McKenzie-Willamette	104	Springfield/Lane	39,925
Sacred Heart	460	Eugene/Lane	103,100
Western Lane	32	Florence/Lane	4,505
MSA Total: beds = 688; population = 267,900; beds per 1000 population = 2.57			
Linn-Benton Counties: (the area between the two MSAs, see Ex. 1)			
Albany General	106	Albany/Linn	27,500
Good Samaritan	188	Corvallis/Benton	41,570
Lebanon Community	96	Lebanon/Linn	10,380
Linn-Benton Total: beds = 390; population = 157,450; beds per 1000 population = 2.48			

Sources:

1/ HAS/Monitrend Reports: August, 1984

2/ "Population Estimates of Oregon Counties and Incorporated Cities: July 1, 1983", Center for Population Research and Census, Portland State University

EXHIBIT 3 HIGHLIGHTS

Title -	Medicare Base DRG Rates, "Urban" and "Rural"
Contents -	The "base DRG rates" and method of calculation are shown for Albany General Hospital and for the hospitals in the two MSAs. The base rate is the average DRG amount per patient that Medicare will pay hospitals during federal fiscal year 1985, assuming a case mix index of 1.0 and 100% reimbursement based on DRGs. The actual average reimbursement per patient will be based 50% on DRGs and will be adjusted to reflect each hospital's actual case mix index.
Observations -	The base DRG rates for hospitals in the Salem and Eugene-Springfield MSAs are greater than the base rate for Albany General Hospital by $783.68 (32.7%) and $575.21 (24.0%), respectively. The rate differentials are intended to reflect differences in the unit resource costs (e. g., average nursing salaries per hour) faced by each hospital. The federal figures are national averages; the regional numbers are averages for all MSAs and non-MSA areas in Alaska, Hawaii, California, Oregon, and Washington. The urban wage indexes were determined for each MSA; the rural index used in computing the AGH base DRG rate is a statewide average for all areas not in an MSA. There is no provision to adjust DRG rates for individual hospitals whose unit resource costs may deviate significantly from the large geographical area averages used to determine the various rates.

Exhibit 3

MEDICARE BASE DRG RATES, "URBAN" AND "RURAL" /1
Fiscal year ended 9/30/85

ALBANY GENERAL HOSPITAL: (based on rural rates)

Labor component-						
Regional (75%)	$ 1999.49	x	0.75	=	$ 1499.62	
Federal (25%)	$ 1943.21	x	0.25	=	485.80	
					1985.42	
x Wage index factor					x 0.9543	
						$ 1894.69
Non-labor component -						
Regional (75%)	$ 521.49	x	0.75	=	$ 391.12	
Federal (25%)	$ 438.18	x	0.25	=	109.54	
						$ 500.66
TOTAL BASE DRG RATE						$ 2395.35

HOSPITALS IN SALEM MSA: (based on urban rates)

Labor component-						
Regional (75%)	$ 2325.13	x	0.75	=	$ 1743.85	
Federal (25%)	$ 2320.61	x	0.25	=	580.15	
					2324.00	
x Wage index factor					x 1.0559	
						$ 2453.91
Non-labor component -						
Regional (75%)	$ 745.34	x	0.75	=	$ 559.00	
Federal (25%)	$ 664.44	x	0.25	=	166.11	
						$ 725.12
TOTAL BASE DRG RATE						$ 3179.03

HOSPITALS IN EUGENE-SPRINGFIELD MSA: (based on urban rates)

Labor component-						
Regional (75%)	$ 2325.13	x	0.75	=	$ 1743.85	
Federal (25%)	$ 2320.61	x	0.25	=	580.15	
					2324.00	
x Wage index factor					x 0.9662	
						$ 2245.45
Non-labor component -						
Regional (75%)	$ 745.34	x	0.75	=	$ 559.00	
Federal (25%)	$ 664.44	x	0.25	=	166.11	
						$ 725.12
TOTAL BASE DRG RATE						$ 2970.56

/1 DRG weight = 1.0

EXHIBIT 4 HIGHLIGHTS

Title - Comparison of Albany General Hospital Wage Rates with Rates Paid by Hospitals in Nearby MSAs

Contents - The exhibit shows the average hourly wage rates paid by Albany General Hospital and by 5 hospitals in the nearby MSAs for the 12 payroll categories with the largest number of hospital employees statewide. The data were taken from the fall 1984 wage and salary survey conducted by the Oregon Association of Hospitals. The four other hospitals in the MSAs are omitted from the exhibit because they either did not participate in the survey or could not be identified from the coded data. However, the excluded hospitals are quite small (average 40 beds) and are not located in the principal urbanized areas of the MSAs.

Observations - The relative rankings of the hospitals vary among the twelve categories, reflecting differences in average seniority as well as some variations in pay scales. Ranking the hospitals from low (1) to high (6) on the average hourly wage rate paid in each category, Albany General has an average rank of 3.5, which is the median rank of the group (half above, half below). */ AGH is above the median in 5 categories, at the median in 2, and below the median in 5. In terms of dollar amounts, the average Albany rate is 1.1% above the median across the 12 categories. Thus, Albany General's unit resource costs for labor are at the same level as the hospitals in the nearby MSAs, not 77 to 84% of these levels, as implied by the labor component of their respective DRG rates.

Employee salaries and benefits normally comprise more than half of all hospital costs. Wage rates are primarily determined by the marketplace and are subject only to minimal control by the hospital. Albany General cannot be expected to lower its salaries by 20 percent or so, as would be required to offset the Medicare urban/rural rate differential.

*/ In computing the average rankings, the ranks were adjusted by a factor of 1.2 in the categories where only 5 of the 6 hospitals reported. This maintains a consistent base of 6 for all the categories.

Exhibit 4

COMPARISON OF ALBANY GENERAL HOSPITAL WAGE RATES WITH RATES PAID BY HOSPITALS IN NEARBY MSAs

The Twelve Payroll Categories With The Most Employees Statewide
(Rankings: 1 = lowest; 6 = highest)

HOSPITAL

		Albany General	Salem Hospital	McKenzie Will.	Sacred Heart	Eugene Hospital	Western Lane
RN	$	10.75	11.39	11.03	11.04	11.62	10.66
	Rank	2	5	3	4	6	1
LPN		8.23	7.50	8.17	7.58	7.75	NA
	Rank	5	1	4	2	3	NA
Aide/ Orderly		5.97	6.63	6.01	6.04	6.01	5.62
	Rank	2	6	4	5	3	1
Housekeeper I		6.02	6.27	5.70	5.36	5.57	NA
	Rank	4	5	3	1	2	NA
Kitchen Worker		5.69	5.76	5.43	5.23	5.04	4.96
	Rank	5	6	4	3	2	1
Medical Technologist		11.64	11.84	11.66	11.25	11.47	10.92
	Rank	4	6	5	2	3	1
Unit Clerk		6.33	7.11	6.52	6.37	6.76	6.07
	Rank	2	6	4	3	5	1
Admitting Clerk		6.50	6.57	6.30	6.28	6.98	5.37
	Rank	4	5	3	2	6	1
Housekeeper II		6.73	7.12	6.41	NA	7.32	5.13
	Rank	3	4	2	NA	5	1
Radiology Tech. (regular staff)		9.39	9.68	NA	9.49	9.05	9.87
	Rank	2	4	NA	3	1	5
Transcriber		7.51	7.72	7.71	7.34	7.68	7.01
	Rank	3	6	5	2	4	1
Head RN		14.11	14.19	13.72	14.26	11.81	NA
	Rank	3	4	2	5	1	NA

Note: The other four hospitals in the Salem and Eugene-Springfield MSAs either did not participate in the survey or could not be identified from the coded results. These are small hospitals (average 40 beds) located outside the major urbanized areas of the MSAs.

Source: Oregon Association of Hospitals Wage and Salary Survey - Fall, 1984

EXHIBIT 5 HIGHLIGHTS

Title - Comparative Hospital Statistics, Resource Costs, and Productivity Indicators

Contents - The exhibit has one column for Albany General Hospital and one for each of the 9 hospitals in the nearby MSAs. The "General Statistics" section includes bed size, various utilization measures, case mix index, and base DRG rate for each hospital. The "Resource Cost Indicators" section shows unit costs for various kinds of expenses: wages, employee benefits, utilities, laundry, dietary, and liability insurance. The "Productivity Indicators" section provides data to indicate the amount of resources used by each hospital in providing various units of service (e. g., nursing hours per patient day).

Observations - Albany General Hospital is larger and has a higher case mix index (i. e., a greater average acuity of patient illness) than 7 of the 9 MSA hospitals. Its unit resource costs are above the median in 5 of the 7 categories listed. Its productivity is better than the median for 4 of the 6 indicators.

Exhibit 5

COMPARATIVE HOSPITAL STATISTICS, RESOURCE COSTS, AND PRODUCTIVITY INDICATORS

For the Twelve Months Ended June 30, 1984
(Source: HAS/MONITREND REPORTS, AUGUST 1984)

		HOSPITAL									
GENERAL STATISTICS:		Albany General	Salem Hospital	Santiam Memorial	Silverton Hospital	Valley Community	Mckenzie-Will.	Sacred Heart	Eugene Hospital	Cottage Grove	Weste Lan
Beds		106	434	40	38	44	104	460	57	35	
Average daily census		57.9	317.9	9.9	16.5	18.0	59.5	295.5	35.5	18.7	10
Occupancy %		54.7	73.3	24.9	43.4	41.0	57.2	64.2	62.2	53.3	33.
Average length of stay		4.50	5.37	3.69	3.49	4.01	4.51	5.80	4.77	3.82	4.
Number of discharges		4715	21668	988	1729	1644	4828	17475	2722	1788	9
% discharges > age 65		NA	37.4	44.6	NA	NA	27.0	29.4	0.0	38.9	20.
Case mix index (9/83)		1.1219	1.1109	1.0097	0.9990	1.0011	1.0357	1.1882	1.1512	1.0213	0.99
Base DRG rate (See Ex. 3)		2395.35	3179.03	3179.03	3179.03	3179.03	2970.56	2970.56	2970.56	2970.56	2970.
RESOURCE COST INDICATORS:		(Rank: 1 = lowest cost; 10 = highest cost; 5.5 = median))									
Nursing units average	(Amt)	10.25	10.23	8.44	12.53	14.39	10.07	10.30	10.67	9.45	7.
salary per hour	(Rnk)	6	5	2	9	10	4	7	8	3	
Employee benefits %	(Amt)	17.77	17.21	15.06	18.16	16.06	19.67	18.24	22.26	16.41	19.
of salaries	(Rnk)	5	4	1	7	2	9	6	10	3	
Overall average	(Amt)	10.12	9.76	8.28	12.53	12.60	10.04	9.67	9.69	9.40	8.
salary per hour	(Rnk)	8	6	2	9	10	7	4	5	3	
Utilities direct expense	(Amt)	185.70	175.61	315.24	167.17	244.97	213.20	137.08	NA	173.95	124.
per 1000 sq. ft.	(Rnk)	6	5	9	3	8	7	2	NA	4	
Laundry direct expense	(Amt)	7.26	4.40	4.31	9.55	5.32	6.19	6.45	8.24	5.15	5.
per patient day	(Rnk)	8	2	1	10	4	6	7	9	3	
Dietary direct expense	(Amt)	369.62	433.03	488.96	542.93	469.63	329.02	193.39	367.06	320.39	617.
per 100 meals	(Rnk)	5	6	8	9	7	3	1	4	2	1
Professional liability	(Amt)	99.10	83.18	55.75	NA	94.80	74.67	78.26	87.72	87.69	63.
insurance cost per bed	(Rnk)	9	5	1	NA	8	3	4	7	6	
PRODUCTIVITY INDICATORS:		(Rank: 1 = highest productivity; 10 = lowest productivity; 5.5 = median))									
Total FTE per adjusted	(Amt)	3.56	3.64	4.09	3.33	3.61	4.00	4.09	3.09	3.54	5.
occupied bed	(Rnk)	5	6	9	2	5	7	8	1	3	1
Total paid hours per	(Amt)	20.18	20.67	23.22	18.88	20.50	22.67	23.18	17.51	20.07	30.
adjusted patient day	(Rnk)	4	6	9	2	5	7	8	1	3	1
Paid nursing hours per	(Amt)	8.23	8.85	12.36	7.78	6.76	7.74	8.97	8.69	8.33	12.4
patient day	(Rnk)	4	6	9	3	1	2	8	7	5	1
Discharges per bed	(Amt)	3.71	4.16	2.06	3.79	3.11	3.87	3.38	3.98	4.26	2.4
per month	(Rnk)	6	2	10	5	8	4	7	3	1	
Laundry pounds per	(Amt)	22.80	19.76	18.95	19.47	31.10	28.48	17.35	23.73	22.08	18.
patient day	(Rnk)	7	5	3	4	10	9	1	8	6	
Paid dietary hours	(Amt)	26.60	32.84	58.45	49.16	32.63	25.26	28.62	27.81	27.78	59.
per 100 meals	(Rnk)	2	7	9	8	6	1	5	4	3	1

Salem, Santiam Memorial, Silverton, and Valley Community Hospitals (located in the Salem MSA) receive a 32.7% higher base DRG rate than Albany General Hospital; Mckenzie-Willamette, Sacred Heart, Eugene, Cottage Grove, and Western Lane Hospi- (Eugene MSA) receive a 24.0% higher rate than Albany General. These higher rates are for identical patients and are determined solely by the location of the identified hospitals in one of the two MSAs, not by any measure of resource costs or productivity (efficiency).

EXHIBIT 6 HIGHLIGHTS

Title - Revenue Impact on Albany General Hospital

Contents - The exhibit shows how much less Medicare revenue AGH is projected to receive this year than any hospital in the two nearby MSAs would get for exactly the same patients.

Observations - The projected revenue deficit varies from about $490,000 to $670,000, depending on which MSA one uses as the basis for comparison. In effect, Albany General Hospital - although having to pay about the same amount for salaries and other resource costs - is being asked to care for Medicare patients in return for a much lower payment.

Exhibit 6

ALBANY GENERAL HOSPITAL ESTIMATED REVENUE DEFICIT DUE TO DRG URBAN/RURAL RATE DIFFERENCES
(Federal Fiscal Year 1985)

DEFICIT COMPARED TO SALEM MSA RATES:

Projected Number of Medicare Patients	x	Rate Difference per Patient	x	Case Mix Index /*	x	Fraction DRG-based Payment	=	Projected Revenue Deficit
1540	x	783.68	x	1.11012	x	0.50	=	$ 669,884

DEFICIT COMPARED TO EUGENE-SPRINGFIELD MSA RATES:

Projected Number of Medicare Patients	x	Rate Difference per Patient	x	Case Mix Index /*	x	Fraction DRG-based Payment	=	Projected Revenue Deficit
1540	x	575.21	x	1.11012	x	0.50	=	$ 491,685

The deficit projections represent the amount by which Albany General Hospital Medicare payments will fall short of the payment that any hospital in the two MSAs would receive for exactly the same patients.

HEARING ON RURAL HOSPITALS UNDER MEDICARE, MAY 9, 1986

I am the Vice-President of the Board of Trustees of Alpena General Hospital, in Alpena, Michigan.

Alpena is a rural community, located over 140 miles, and at least 2 1/2 hours drive, from any city with a population over 50,000 people. It is the shopping, employment and medical center for all of Northeast Michigan. Alpena General is the only hospital in the County and is the primary source of specialized care for the three surrounding counties, as well as parts of three other counties. Small community hospitals and clinics in surrounding counties refer patients to Alpena General Hospital for the specialty care that is available there. It is truly a medical referral center for its region. The Hospital Board and Administration has encouraged this status by active recruitment of specialists. For example, Alpena has the only gynecologists, opthamologist, cardiologist, urologist, pathologist, pulmonologist and psychiatrist within a 100 mile radius.

In fiscal 1985 we were reimbursed by Medicare as an ordinary rural hospital. We went through massive layoffs, lost large sums of money and faced a community uprising. In fiscal 1986, we were reimbursed by Medicare as a Regional Referral Center and we are operating at a comfortable level, with community support and approval.

Alpena General Hospital, along with nearly every other hospital that I know of, has felt a declining number of admissions over the past several years. Again, the Hospital Board and Administration has encouraged this trend by the provision of new facilities and equipment for outpatient surgery and careful monitoring of admissions. The trend to lower numbers of admissions serves the patients, the economy and the taxpayers.

However, as this trend continues downward, it becomes unlikely that our hospital will attain the 6000 annual discharges necessary to retain our status as a Regional Referral Center for medicare reimbursement. Loss of this status will result in further massive layoffs and a retrenchment in the quality of medical care in this area.

I am not sophisticated enough to know the basis for the establishment of 6,000 discharges as a qualification for Regional Referral Status. I know that we are a regional referral center whether we are reimbursed on that basis or not. I know that we will not be able to provide our present level of care without the Medicare reimbursement status as a REgional Referral Center. I believe that, if 6,000 discharges was an appropriate level three years ago, some lesser number of discharges is an appropriate level now.

I am aware of the need to reduce the cost of the Medicare system and I support this goal. I am also aware of the ease of drawing simple but arbitrary criteria which determines qualifications for very complex issues. I believe that this "easy way out" approach may have been used with regard to the discharge standard for Regional Referral Status. If a standard couched in terms of an absolute number of discharges is needed, then the existing standard is too high. If it operates to deprive the people of Northeast Michigan of a referral facility, it works an injustice. I cannot believe that Alpena General Hospital is alone in suffering this injustice.

There is no policy reason why areas with small populations should be forced to drive substantial distances in order to receive the benefit of medical care, which has become the standard of care based upon an arbitrary number of admission.

Sincerely,

James L. Mazrum

JLM:pdh

Additional letters were received from Alpena General Hospital and are in the official committee files.

American
Healthcare
Institute

Affiliated with American Healthcare Systems

Merlin K. DuVal, M.D.
President

RURAL HOSPITALS UNDER THE MEDICARE PROGRAM

Finance Committee Subcommittee on Health

May 9, 1986

Mr. Chairman, I am Merlin K. Duval, president of the American Healthcare Institute, and I am pleased to offer the views of the Institute on Medicare payment of rural hospitals.

The American Healthcare Institute is the research, education and policy arm of American Healthcare Systems, which represents 35 large not-for-profit multi-hospital systems. In the aggregate, they own, lease or manage approximately 500 hospitals and render services to another 950 hospitals through affiliate arrangements. In the aggregate, this encompasses almost 100,000 beds, over 300,000 employees, and $14 billion in revenue. This makes the organization the largest network of not-for-profit hospitals in the world.

We suggest to the committee that among the public policy objectives of Medicare payment to rural hospitals should be:

- to encourage the continuing restructuring of rural and urban health care in ways that both contain national costs and provide reasonable access to adequate health care to rural Medicare beneficiaries.

1919 Pennsylvania Avenue • N.W. • Suite 703 • Washington, D.C. 20006 • 202 293-2840

THE PROBLEM

Hospitals of all types today find themselves in a period of profound change that holds great promise for lowering the costs and improving the access and quality of care for most Americans for the vast majority of services. This change ultimately also holds great promise for many rural communities. However, the constraints on rural hospitals' capacity to respond to the economic pressures associated with this period could result in cutbacks in services, closures, and loss of the rural hospital's unique role in assuring accessible and quality care to rural communities.

THE POTENTIAL OF COMPETITION FOR IMPROVING HEALTH CARE IN RURAL AMERICA

We want to stress that we are supportive of the competitive market developing in health care and believe that it holds great promise for our health care system and those it treats. The availability of new technologies that allow more care to be given in ambulatory settings, increasing availability of non-hospital sources of care, and new third party payment systems (such as Medicare's prospective payment system) are among the factors creating constructive market pressures and opportunities for providers to move health care out of the hospital into more accessible ambulatory settings and hold down costs to patients and their insurers. Market forces are likely to produce an improved health care system that has fewer hospital beds, but still offers accessible and economical care.

These forces are also operating in rural communities. Like their urban competitors, rural hospitals are offering more of their services on outpatient and ambulatory bases. They are reducing their inpatient capacity, and have cut their operating costs drastically during recent years. They are also exploring joint ventures with physicians and other hospitals to establish networks of care and even HMO's and other capitated systems of care. Mr. Chairman, many of these changes would have been thought unlikely or impossible in rural areas just a few years ago.

THE THREAT OF COMPETITION TO RURAL HEALTH CARE

In the short run, however, these market forces can cause deterioration in the accessibility of care in rural areas. In order to survive and continue their missions in this competitive market, all hospitals must raise enough revenues to invest in and cover the initial operating losses of new ways to organize and deliver care. We believe that rural hospitals are disadvantaged in this competition for revenue to support change by their very nature and mission.

Like most other hospitals, rural hospitals today find their inpatient volume and revenues shrinking faster than they can reduce costs, or otherwise restructure their services. Part of this reduced volume is due to the changes in technology and sites of care mentioned above and part is due to the efforts of other hospitals, particularly urban hospitals, to reach out for rural patients to bolster their own falling patient volumes. In addition, revenues are shrinking because public and private third party payer's new payment systems (including the Medicare DRG system) do not take account of the special role and cost environment of rural hospitals, and underpay these institutions. Finally, public payers--pressured by budgetary concerns--have chosen to take advantage of the growing "buyer's market" in hospital care to reduce their payment levels well below the competitive prices originally envisioned as appropriate incentives in the new prospective payment and capitation systems. Medicare, now reinforced by the deficit reduction imperative of the Gramm-Rudman Act, has embarked on a budget cutting pattern that promises to pay more and more constrained DRG prices to hospitals during years to come.

These financial pressures catch rural hospitals at a time when they are especially vulnerable.

Indeed, the current hospital market will not permit many rural hospitals to continue the unique role they play in rural communities and at the same time raise revenue to restructure their services, cut prices to compete with urban hospitals, and accept inadequate and even arbitrarily reduced payments from Medicare and other public payers. Many rural hospitals are being forced by inadequate payments to consider closure, radical reductions in services, or types of joint venture or consolidation with urban hospitals that they believe will compromise services to their rural communities.

Inadequate payment levels are making rural hospitals easy targets for urban hospitals seeking more patients, and, in the end, can cause less accessible and lower quality care for the rural community as well as the loss of many rural hospital functions.

Let us spell out in more detail the special characteristics of rural hospitals that Medicare and other payments fail to take into account.

THE UNIQUE ROLE AND COSTS OF THE RURAL HOSPITAL

Rural hospitals must offer a broad range of services responsive to the needs of the community and its physicians, and yet they are small in size.

Small rural hospitals serve as the primary source of hospital and laboratory services in their communities. Indeed in many communities they serve as the focal point of community concern and action with regard to the health needs of their people, and are governed by boards and supported by community groups that think of them as community resources. This leads them to be involved in a range of activities not always expected of hospitals operating in urban markets. Rural facilities may well conduct school health, community health education and health promotion, and a variety of outreach programs responsive to the particular needs of a widely dispersed farming population. In addition, they are obliged to take any citizen who needs help regardless of his or her ability to pay--for all practical purposes, there is nowhere else for the patient to go and the ethic of the community requires that care be given.

This unique role of the rural hospital also results in it providing a far broader array of services than would normally be associated with its small size. These services include all of the front line hospital and laboratory services that the community and its physicians feel people should not have to travel long distances to obtain in larger urban facilities. They may also offer more specialized services when the needs of the community clearly support these needs. For example, some rural hospitals have developed special skills in caring for farming accident victims.

Rural communities and their physicians would agree that for many sophisticated services travel to an urban hospital is not a major problem and is the best assurance of economical and high quality care. But for many other services, quicker access to first line or primary hospital based services is critical to successful treatment, or to stabilization and referral of the patient to a more completely equipped but distant facility. In still other cases they would argue, patients seek treatment earlier and follow through with treatment regimens (including post inpatient care) more consistently when hospital care is nearer to their homes. Finally, rural communities often find it more difficult to attract adequate physicians into their area if they are not able to offer the primary or first line hospital and laboratory services that physicians feel they need available to offer adequate care.

All of which is to say that for Americans in rural areas, primary or first line hospital services, and in some cases more specialized services, are critical to timely, effective, and quality health care.

Because rural hospitals are necessarily small due to the widely dispersed small population they serve, these unique roles give rise to higher than usual costs and greater vulnerability to the financial pressures of the current competitive marketplace.

Rural hospitals face unpredictable variations in patient volume, higher stand-by costs, lower economies of scale, and greater difficulty in obtaining capital than their larger urban hospital counterparts.

LOWER ECONOMIES OF SCALE AND HIGHER STAND-BY COSTS

While the patient volume and size of the rural hospital is small, the hospital is nevertheless expected to offer a broad range of health services. Consequently, such a hospital must make available facilities, personnel, and equipment that are not always utilized to their full capacity. For example, diagnostic equipment (such as x-ray) must be available to diagnose a variety of conditions, including many injuries, but is unlikely to be used as fully as it would be in a larger hospital. Similarly, minimum nursing staffing levels must be maintained around the clock, regardless of the actual number of inpatients or night-time admissions.

In fact, rural hospitals must maintain some equipment and facilities on a stand-by basis because they are of critical importance, even though they are very seldom used. While all hospitals must do this to some degree, rural hospitals must finance the costs of such resources across a smaller revenue base because they are the only source of care for a small and often dispersed population.

This means the costs of many rural hospital services are spread over a fewer number of patients, raising the per patient or per case costs. Larger hospitals with higher patient volumes can more fully utilize their resources, spreading their fixed or stand-by costs over more patients or cases, and lowering their costs per patient or per case.

GREATER FLUCTUATIONS IN VOLUME

In addition to these higher costs, rural hospitals must maintain higher reserves or be prepared to borrow operating capital to carry them through greater fluctuations in their patient volume than larger hospitals. It is an accepted rule of probability that greater fluctuations and variations occur in smaller populations than in larger ones. These fluctuations add to the hospitals' costs and the likelihood of future variations must be taken into account in the hospitals charges and reserves levels. Because the likelihood of these unanticipated variations is greater for rural hospitals than for larger hospitals, a higher increment must be added to charges to create adequate reserves than is usually needed in a larger urban facility.

These variations in patient volume must be distinguished from longer term declines in volume that may occur over time and indicate that a hospital may eventually consider downsizing or even closing. The increasingly price competitive market ultimately will prevent some hospitals from increasing their charges enough to cover such long-term declines, and it is in the best interest of the health care system for such hospitals to downsize or close. However, price competition also makes it very difficult for rural hospitals to create adequate reserves to cover their inevitable situations in volume unless consideration of this phenomenon is built into third-party payer's payment rates (including Medicare).

GREATER DIFFICULTY OBTAINING CAPITAL

Finally, rural hospitals are handicapped in obtaining capital to finance their restructuring activities by their small size and their consequent vulnerability to variations in volume and revenue. They find it harder than do their urban counterparts to generate capital internally or establish credit worthiness for long-term low interest financing from lenders to cover such desirable changes. For example, unlike urban hospitals they cannot specialize in services or on patients that are especially profitable under the DRG system, or market only to higher paying segments of the privately insured populations in their areas. They are, after all, the only care practically available. They are bound by their mission and governance to offer all needed primary services to all residents.

Mr. Chairman, we believe these problems of rural hospitals must be taken account of in the way Medicare pays for their services if rural Americans are to receive adequate health care. The need to make changes to accommodate to these needs is urgent. The health care system is changing rapidly. If we delay for too long the fate of the rural community will be sealed in ways that will take a long time to correct. Let me repeat that we want solutions to these problems that are consistent with the competitive market. We would like to work with the committee to this end.

Thank you for this opportunity to present our views.

ALBEMARLE HOSPITAL

Office of the Associate Administrator

May 19, 1986

Ms. Betty Scott-Boom
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

"Hearing on Rural Hospital Under Medicare - May 9, 1986"

Albemarle Hospital supports the testimony given by Caylor-Nickel Hospital before the Senate Finance Committee, subcommittee on health, on May 9, 1986.

Like Caylor-Nickel Hospital, Albemarle Hospital is a designated Rural Referral Center under the Medicare prospective payment system. Albemarle Hospital provides medical services to a seven-county area of northeastern North Carolina. However, we must compete with the urban area of Tidewater, Virginia for professional personnel and manpower. Our various operating supplies and materials are just as costly in our rural setting as it is in an urban one. We provide many specialized services to our community beyond a hospital our size.

We face loosing our designated Rural Referral Center status, like Caylor-Nickel Hospital by doing a job too well. In responding to the prospective payment mechanism, we have had our admissions decreased to a point where we will not be eligible in the future for this program. Our inpatient admissions have shown the following decreases from 1980-1985:

Admissions

1980	1981	1982	1983	1984	1985
6,966	7,240	7,097	6,957	5,950	5,642

This decrease has been offset by outpatient procedures, like our Ambulatory Surgery Program initiated in 1982. The following figures reflect this increase:

1980	1981	1982	1983	1984	1985
0	0	294	706	892	958

This switch to outpatient delivery of medical care is also seen in the ancillary departments of the hospital. For instance, in 1980 in Radiology 50.4% of all procedures were done on an outpatient basis. By 1985, this had moved to 63.4%. In Physical Therapy, our percentage of outpatient procedures were 28.2%. By 1985, this percentage had moved up to 58.6%.

Albemarle Hospital has responded to its community health needs by providing and increasing the availability of a broad scope of specialized medical services. Our costs continue to increase. And we have responded to the general thrust of the Medicare's prospective payment system by switching many medical treatments from an inpatient setting to an outpatient one. However, if the criteria to remain a Rural Referral Center is not changed, Albemarle Hospital will not qualify in the years to come. This loss of revenue compensating us for our specialized medical care will be a serious revenue loss to our institution, jeopardizing those services we now provide to our community. We, along with Caylor-Nickel Hospital, request your

Hearing on Rural Hospital Under Medicare
May 19, 1986
Page Three

serious consideration in having the NCFA requirement of admissions criteria changed for Rural Referral Centers.

Yours very truly,

for Ernest A Malcolm, Jr / Assoc Adm

Robert G. Jeffries
Administrator

RGJ/bs

CC: The Honorable John P. East
The Honorable Jesse A. Helms

American Psychiatric Association
1400 K Street, N.W., Washington, D.C. 20005 • Telephone: (202) 682-6000

STATEMENT

OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

ON

RURAL HOSPITALS UNDER THE
MEDICARE PROGRAM

MAY 9, 1986

The American Psychiatric Association, a medical specialty society representing over 32,000 physicians nationwide, is pleased to have the opportunity to submit testimony concerning rural hospitals under the Medicare Program.

Our testimony focuses on concerns about the mental health needs of rural elderly Americans; availability of hospital beds for psychiatric care in rural areas; and problems that rural hospitals may be facing in meeting the mental health needs of their elderly population. As with all aspects of the health system, the mental health delivery system functions best for patients when prehospital, hospital, and posthospital care are coordinated. Our consistent pattern of anecdotal information about the problems encountered in rural areas is substantive evidence of areas of concern. The Medicare Program's discrimination against psychiatric service provision may further exacerbate the problems of rural elderly people. (The 190 day limit on hospitalization in psychiatric facilities and the $250 limit (after deductible and copayment) on outpatient care.)

Stress in Rural Areas

Concerns about the mental health of rural American families have resulted in hearings held by Senator Durenberger in Minnesota and in a Rural Stress Policy Forum conducted by the National Institute of Mental Health on April 4 and 5 1986 in Chicago, Illinois. Attendees at the NIMH conference included key government officials, national organizations, providers and researchers. Both the hearing and the forum found increased utilization of mental health services, and increases in suicide and suicide attempts in rural areas.

Studies reported at the NIMH Policy Forum on Rural Stress demonstrate the increasing mental health problems in rural areas. From the studies conducted on younger populations, we can infer some of the problems the elderly may be facing. First, research at the University of Minnesota in three Minnesota communities has documented the increasing stress, depression, and suicides in the adolescent population. Depression is approximately two times the national average in the 15-19 year old population. Out of every 100 adolescents surveyed, three had attempted suicide in the month preceding the survey. In addition to self-reported depression, on a standardized measure of depression (Beck scale) adolescents living in rural homes had higher average Beck depression scale scores than adolescents hospitalized at the UCLA Neuropsychiatric Institute. Compared to a similar study in New York twice the number of adolescents were moderately or severely depressed.

Second, a study conducted at the University of Missouri examined farm families forced out of farming for financial reasons. All women and the majority of men in the 42 families studied indicated they had experienced depression at some time during the course of the financial problems with their farms. Many (over half the men and 3/4 of the women) continued to experience depression even after some settlement was reached. Increased substance abuse, withdrawal, and physical aggression were also noted.

Estimates of mental health problems of the elderly indicate that 15 to 20 percent -- between 3 and 5 million -- of our nation's more than 25 million elderly Americans have significant mental health problems. In addition, twenty to thirty percent of older Americans labeled "senile" actually have reversible, treatable conditions. It is well recognized that general assaults on the self esteem of elderly people put them, in general, at significant emotional risk. This is evident in the fact that in 1982, individuals over age 65 accounted for 10% of the population, but 17% of death by suicide. Additional financial problems in rural areas and the self-sufficiency of elderly individuals may produce extreme stress, but the self-sufficency of rural Americans and the dispersion of services may result in an unwillingness to seek service until mental health problems produce a major crisis. Estimates also indicate that the elderly population receive as much as half of all prescribed barbituates and sedative medication. Given that the population of elderly rural Americans has grown 30% since 1960 (while the general rural population has grown 10%), it is probable that the need for use of mental health services including hospitalization has also increased significantly.

In addition to the statistics cited above, one study conducted at Kansas State University found that between 12 and 23% of a mostly rural elderly population showed significant psychiatric symptomatology (Scheidt and Windley). Thousands of elderly people in 18 small towns (not all of which were rural) located in rural counties were interviewed and administered three standardized scales (Langler screening scale, Bradburn affect Balance Scale, Philadelphia Geriatric Morale Scale). Fifteen - twenty percent of the study group demonstrated psychiatric problems on the standardized scales. Only one percent of this frail elderly population had sought out mental health services for their concerns. Many of the elderly people interviewed had physical as well as emotional problems and felt isolated from family and friends.

Availability of Psychiatric Beds in Rurual Areas

Data from the American Hospital Association's 1984 Annual Survey of hospitals indicates that in non-SMSA areas of the country, there are a total of 13,320 beds for psychiatric acute care (less than 30 days), and 12,987 beds for psychiatric long-term care (over 30 days). In addition, there are 4,142 Acute care alcohol/chemical dependency beds and 1,546 long-term alcohol/chemical dependency beds (Chart I) in 2,937 hospitals in registered hospitals. The total beds for these services are approximately 14% of rural beds and may not be adequate given the tremendous current rural beds. Chart II demonstrates that 304 hospitals provide acute psychiatric care and 54 provide long-term psychiatric care.* One hundred fifty-six hospitals provide acute alcohol/chemical dependency services and 51 provide long-term alcohol and chemical dependency services.* (Chart III includes the definitions of psychiatric services used by the American Hospital Association. Chart IV deleneates requirements for becoming a registered hospital).

Because the majority of hospitals are not dedicated psychiatric facilities, one must examine service delivery capability in these hospitals. Kiesler and Sibulkin (1984) report on the disparity of data for the episodic rate of mental hospitalization. Although the rate of hospitalization has remained stable (1.8 million) in recent years in psychiatric hospitals, admissions for psychiatric inpatient episodes in general hospitals increase the total to 3 million, thus, indicating a steady increase in hospitalization rates for mental health episodes from 1965 to 1979. Discharges from general hospitals without psychiatric units occur much more frequently than discharges from hospitals which have distinct-part psychiatric units. (This fact may be even more apparent in rural areas). One study compared the number of people receiving services in the specialty mental health sector versus the General Mental health Sector. Psychiatric units in General Hospitals accounted for over 30% of the inpatient episodes, however, there were twice as many inpatient episodes in general hospitals without psychiatric units (Regier et. al. 1978; Taube et. al. 1978).

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* Some of the hospitals may provide both acute and long-term serivces.

While AHA data theoretically would exclude "scatter beds" from definitions of service delivery, it is possible that some of these programs listed may, in fact, be scatter beds, as hospitals self-report service delivery and some scatter beds, in fact, may represent organized programs but not units per se. Very little is known about scatter beds except that patients admitted to these beds have shorter lengths of stay (7.9 days) than those admitted to separate units (17 days). Their diagnoses are more frequently alcoholism and neuroses, in contrast to diagnoses of schizophrenia and personality disorders in psychiatric units; and the patients tend to be older and represent a higher percentage of men than those admitted to psychiatric units (Kiesler and Sibulkin, 1983). Services provided to these patients are not well-documented, however, one rural area created a scatter bed program because there were not sufficient resources to set up a separate unit (Werner, Knorr and Stack 1977-78).

Lenox Hill Hospital in New York formulated a detailed and formal protocol for a scatter bed program in 1978. Findings from the program indicated that patients with mixed psychiatric medical diagnoses were most appropriate for those scatter beds, but individuals with substance abuse were inappropriate. By using a formal screening system, clinically appropriate patients were admitted to the unit in a manner consistent with the openness of the unit (Collins and Skiest).

Because the potential for existence of scatter beds is large in rural areas, questions may be raised about the extent to which organized programs exist and the extent to which access to the appropriate hospital treatment modality is available in rural areas. Well-organized scatter bed programs may provide appropriate psychiatric supervision, for patients, but less formal programs may have questionable quality of care for the treatment of mental illness.

Rural hospitals are more likely to be financially vulnerable because of fluctuations in case mix and volume (PROPAC Report to Secretary of HHS, April 1986). Patients with mental illness problems in rural areas are also likely to be more vulnerable. Service delivery may be more regionalized, and yet recuperation from mental health problems may require family support.

Patients may seek out psychiatric services only when they are having a crisis or they may not know how to seek out these resources when needed. Some problems psychiatrists have noted include:

1) In a rural community in Texas (25,000 people), one psychiatrist covers five counties. There is one 12 bed inpatient psychiatric unit. Slowdowns in payments to the psychiatrist (member of multi-specialty group with 40% Medicare patients) and to hospitals are a significant problem. Rural hospitals cannot bear the financial risk of inconsistent payment.

2) In a rural area of Michigan, the nearest psychiatric hospital was 100 miles away and the nearest state mental hospital was 200 miles away. When hospitalization is required for major disorders, (not possible to handle in a general unit) there is significant disruption for elderly beneficiaries and their families and potential for further alienation of the elderly patients.

3) In some cases, while partial hospitalization or day treatment may be appropriate modalities, distance from a facility in rural areas may be so great (and Medicare coverage so poor), that the only choice would be to hospitalize a patient.

4) Some rural areas of the country do not have a psychiatrist who can cover a hospital scatter bed program or a rural inpatient psychiatric unit.

5) One state has delayed the transfer of designation of certain hospital units as psychiatric units, because of delays in developing a state health plans. Because of these delays, appropriate well-staffed units cannot be developed.

Reports from psychiatrists in rural areas also indicate that the distances from the facilities in rural areas has, at times, resulted in situations where community mental health service follow-up is hard to implement on a consistent basis.

Concern about mental health issues in rural areas has lead the chair of the American Association of General hospital psychiatrists to begin examining cosponsorship of programs with the American Psychiatric Association, the American Hospital Association's rural hospital committee, and the Hospital and Community psychiatry group.

Summary

Rural elderly people are under significant stress. Financial difficulties in rural areas produce problems for the elderly and for appropriate service delivery. Due to the distance to appropriate facilities, hospitalization at a facility may further alienate the elderly. Rural hospitals experiencing financial difficulties may not be able to allocate the necessary funding for distinct-part psychiatric units. While organized "scatter-bed" programs may serve certain patients well, other patients benefit only from hospitalization in a distinct-part psychiatric unit of a general hospital or in a psychiatric facility. The discriminatory low-level of coverage for psychiatric services under Medicare may further exacerbate the mental health problems of our rural elderly Americans.

CHART I

1984 ANNUAL SURVEY OF HOSPITALS

RURAL* UNITED STATES REGISTERED AND NONREGISTERED HOSPITALS

	Psychiatric		Alcohol/Chemical		Number of
	Acute	Long-Term	Acute	Long-Term	Hospitals
	NUMBER OF BEDS				
Total United States	13,320	12,987	4,142	1,546	2,998
Federal	1,726	1,067	620	189	112
Nonfederal	11,594	11,920	3,522	1,357	2,886
Psychiatric [1]	7,550	11,476	1,885	675	112
TB & Other Resp. Diseases					2
Long-Term Gen. & Other Special [2]	357	444	109	160	24
Short-Term Gen. & Other Special	3,687		1,528	522	2,748
Nongovernment Not-For-Profit	2,782		1,082	413	1,298
Investor-Owned	295		195		261
State and Local Government [3]	610		251	109	1,189
Hospital Units of Institutions	33				11
Community Hospitals	3,654		1,528	522	2,737
Nongovernment Not-For-Profit	2,782		1,082	413	1,297
Investor-Owned	295		195		261
State and Local Government	577		251	109	1,179
6 - 24 BEDS			3		194
25 - 49	20		156	75	821
50 - 99	319		213	119	936
100 - 199	1,475		603	196	609
200 - 299	1,004		357	98	131
300 - 399	559		171	10	34
400 - 499	159		10	24	6
500 or More	118		15		6

SOURCE: American Hospital Association 1984 Annual Survey of Hospitals

* Non SMSA areas of country

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[1] May include state mental hospitals

[2] Includes children's and orthopedic hospitals

[3] Includes state mental hospitals

CHART II

1984 ANNUAL SURVEY OF HOSPITALS

COUNTS

RURAL* UNITED STATES REGISTERED AND NONREGISTERED HOSPITALS

NUMBERS OF HOSPITALS

	Psychiatric		Alcohol/Chemical		Number of
	Acute[1]	Long-Term	Acute	Long-Term	Hospitals
Total United States	304	54	156	51	2,998
Federal	31	8	17	9	112
Nonfederal	273	46	139	42	2,886
Psychiatric	57	42	43	12	112
TB & Other Resp. Diseases					2
Long-Term Gen. & Other Special	6	4	2	1	24
Short-Term Gen. & Other Special	210		94	29	2,748
Nongovernment Not-For-Profit	154		65	21	1,298
Investor-Owned	13		11		261
State and Local Government	43		18	8	1,189
Hospital Units of Institutions	1				11
Community Hospitals	209		94	29	2,737
Nongovernment Not-For-Profit	154		65	21	1,297
Investor-Owned	13		11		261
State and Local Government	42		18	8	1,179
6 - 24 BEDS			1		194
25 - 49	3		12	6	821
50 - 99	23		18	9	936
100 - 199	96		34	7	609
200 - 299	54		19	5	131
300 - 399	23		8	1	34
400 - 499	6		1	1	6
500 or More	4		1		6

SOURCE: American Hospital Association 1984 Annual Survey of Hospitals

* Non SMSA areas of the country

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[1] Some hospitals may have both acute and long-term beds therefore some of the 54 hospitals with long-term beds may also be counted in the 304 beds under acute hospitals

CHART III

DEFINITIONS

ALCOHOLISM/CHEMICAL DEPENDENCY: Provides medical care and/or rehabilitiative services to patients for whom the primary diagnosis is alcoholism or other chemical dependency. Beds must be set up and staffed in a unit specifically designated for this service.

PSYCHIATRIC: Provides care to emotionally disturbed patients, including patients admitted for diagnosis and for treatment of psychiatric problems, on the basis of physicians' orders and approved nursing care plans. May also include the provision of medical care, nursing services, and supervision to the chronically mentally ill, mentally disordered, or other mentally incompetent persons. Beds must be set up and staffed in unit(s) specifically designated for this service.

SOURCE: Hospital Statistics, 1985 Edition, American Hospital Association, 1985

CHART IV

This list includes both hospitals registered by the American Hospital Association and osteopathic hospitals listed by the American Osteopathic Association. Identification codes for both types of hospitals are explained fully on pages A2-4. For the reader's convenience, the codes for osteopathic hospitals are also summarized in the notes at the top of each page of this section. Beginning in November 1970, osteopathic hospitals became eligible to apply for registration by the American Hospital Association. Registered osteopathic hospitals carry the same codes as all other hospitals registered by the American Hospital Association.

AHA-Registered Hospitals

Any institution that can be classified as a hospital according to the requirements may be registered if it so desires. Membership in the American Hospital Association is not a prerequisite.

Requirements for accepting general hospitals for registration*

Function: The primary function of the institution is to provide patient services, diagnostic and therapeutic, for a variety of medical conditions, both surgical and nonsurgical.

1. The institution shall maintain at least six inpatient beds, which shall be continuously available for the care of patients who are nonrelated and who stay on the average in excess of 24 hours per admission.
2. The institution shall be constructed, equipped and maintained to ensure the health and safety of patients and to provide uncrowded, sanitary facilities for the treatment of patients.
3. There shall be an identifiable governing authority legally and morally responsible for the conduct of the hospital.
4. There shall be a chief executive to whom the governing authority delegates the continuous responsibility for the operation of the hospital in accordance with established policy.
5. There shall be an organized medical staff of physicians† that may include, but shall not be limited to, dentists. The medical staff shall be accountable to the governing authority for maintaining proper standards of medical care and it shall be governed by bylaws adopted by said staff and approved by the governing authority.
6. Each patient shall be admitted on the authority of a member of the medical staff who shall be directly responsible for the patient's diagnosis and treatment. Any graduate of a foreign medical school who is permitted to assume responsibilities for patient care shall possess a valid license to practice medicine, or shall be certified by the Educational Commission for Foreign Medical Graduates, or shall have qualified for and have successfully completed an academic year of supervised clinical training under the direction of a medical school approved by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges.
7. Registered nurse supervision and other nursing services are continuous.
8. A current and complete‡ medical record shall be maintained by the institution for each patient and shall be available for reference.
9. Pharmacy service shall be maintained in the institution and shall be supervised by a registered pharmacist.
10. The institution shall provide patients with food service that meets their nutritional and therapeutic requirements; special diets shall also be available.
11. The institution shall maintain diagnostic x-ray service, with facilities and staff for a variety of procedures.
12. The institution shall maintain clinical laboratory service, with facilities and staff for a variety of procedures. Anatomical pathology services shall be regularly and conveniently available.
13. The institution shall maintain operating room service with facilities and staff.

The American Hospital Association may, at the sole discretion of its Board of Trustees, grant, deny or withdraw the registration of an institution.

Requirements for accepting special hospitals for registration*

Function: the primary function of the institution is to provide diagnostic and treatment services for patients who have specified medical conditions, both surgical and nonsurgical.

1. The institution shall maintain at least six inpatient beds, which shall be continuously available for the care of patients who are nonrelated and who stay on the average in excess of 24 hours per admission.
2. The institution shall be constructed, equipped and maintained to ensure the health and safety of patients and to provide uncrowded, sanitary facilities for the treatment of patients.

*Requirements approved by the Board of Trustees, May 1955, and adopted by the House of Delegates, September 1955. Amended June 1956; February 1957; August 1959; May 1963; May 1964; February 1965; February 1970; and August 1971.

†Physician—Term used to describe an individual with an MD or DO degree who is fully licensed to practice medicine in all its phases.

‡The completed records in general shall contain at least the following: the patient's identifying data and consent forms, medical history, record of physical examination, physicians' progress notes, operative notes, nurses' notes, routine x-ray and laboratory reports, doctors' orders, and final diagnosis.

Source: AHA Guide:American Hospital Association Guide to the Health Care Field, 1984 Edition

3. There shall be an identifiable governing authority legally and morally responsible for the conduct of the hospital.
4. There shall be a chief executive to whom the governing authority delegates the continuous responsibility for the operation of the hospital in accordance with established policy.
5. There shall be an organized medical staff of physicians[†] that may include, but shall not be limited to, dentists. The medical staff shall be accountable to the governing authority for maintaining proper standards of medical care and it shall be governed by bylaws adopted by said staff and approved by the governing authority.
6. Each patient shall be admitted on the authority of a member of the medical staff who shall be directly responsible for the patient's diagnosis and treatment. Any graduate of a foreign medical school who is permitted to assume responsibilities for patient care shall possess a valid license to practice medicine, or shall be certified by the Educational Commission for Foreign Medical Graduates, or shall have qualified for and have successfully completed an academic year of supervised clinical training under the direction of a medical school approved by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges.
7. Registered nurse supervision and other nursing services are continuous.
8. A current and complete[‡] medical record shall be maintained by the institution for each patient and shall be available for reference.
9. Pharmacy service shall be maintained in the institution and shall be supervised by a registered pharmacist.
10. The institution shall provide patients with food service that meets their nutritional and therapeutic requirements; special diets shall also be available.
11. Such diagnostic and treatment services as may be determined by the Board of Trustees of the American Hospital Association to be appropriate for the specified medical conditions for which medical services are provided shall be maintained in the institution, with suitable facilities and staff. If such conditions do not normally require diagnostic x-ray service, laboratory service, or operating room service, and if any such services are therefore not maintained in the institution, there shall be written arrangements to make them available to patients requiring them.
12. When the institution provides pregnancy termination services, clinical laboratory services shall include the capability to provide tissue diagnosis.

The American Hospital Association may, at the sole discretion of its Board of Trustees, grant, deny or withdraw the registration of an institution.

AOHA-listed hospitals

The list of osteopathic hospitals furnished by the American Osteopathic Association includes both members and nonmembers of the American Osteopathic Hospital Association.

[†] Physician—Term used to describe an individual with an MD or DO degree who is fully licensed to practice medicine in all its phases.

[‡] The completed records in general shall contain at least the following: the patient's identifying data and consent forms, medical history, record of physical examination, physicians' progress notes, operative notes, nurses' notes, routine x-ray and laboratory reports, doctors' orders, and final diagnosis.

Community Health Center
of Branch County
Coldwater, MI 49036-2088 • Phone 517/278-7361

May 16, 1986

Ms. Betty Scott-Boom
Committee on Finance
219 Dirksen Senate
Office Building
Washington, DC 20510

HEARING ON RURAL HOSPITALS UNDER MEDICARE - MAY 9, 1986

Attached you will find the Testimony of the experience of the Community Health Center of Branch County under the Prospective Payment System. The Health Center is very concerned about the outcome of these hearings and any changes to the Prospective Payment System which would enhance the viability of rural hospitals would be greatly appreciated both by the hospital and by the people that we serve.

I would like to emphasize that if the hospital were eight (8) miles north, we would be classified as an urban hospital. I think that small geographical distance really does not affect the cost of health care, but if reimbursement policies are not changed, it will definitely affect the quality of health care to the people of Branch County.

Thank you for your cooperation in this matter.

Sincerely,

David J. Ameen
Chief Executive Officer

DJA/d
Attachments
cc: Senator Carl Levin
Senator Donald Riegle
Representative Mark Siljander

TESTIMONY OF COMMUNITY HEALTH CENTER OF BRANCH COUNTY

We appreciate the opportunity to inform the Committee of the experience of the Community Health Center of Branch County ("CHC") under the Medicare Prospective Payment System ("PPS").

The Community Health Center is a 130 bed, county hospital located in Coldwater, Branch County, Michigan. CHC is 35 miles from the nearest metropolitan area of Battle Creek, Michigan and is a major regional provider of health care services. CHC's full-time active medical staff represents 16 different specialties and subspecialties. The staff is 70% Board Certified or Eligible in a recognized specialty. Most of the specialists are other than general Family Practitioners, which is the most common community hospital specialty. Our case mix index, which is the Medicare formula to measure the complexity of medical services performed in a hospital is 1.1046. This greatly exceeds the median urban index for our region, indicating that CHC is performing more specialized medicine than most urban hospitals in the six-state region encompassing Minnesota, Wisconsin, Illinois, Michigan, Indiana and Ohio.

CHC has been in the forefront of those institutions taking an active role in reducing health care costs to the consumer. We have increased utilization of non-invasive high technology diagnostics; such as, ultrasound and fiber-optic equipment to help reduce the need for hospitalization and invasive surgery. Our ambulatory surgery program, which did not exist in 1980, each year has exceeded annual projections. We served 758 patients through the program fiscal year 1982; 1,174 in fiscal year 1983; 1,938 in fiscal year 1984, 2,672 in fiscal year 1985. Currently, 57% of the surgeries performed at CHC are performed on an out-patient basis. In fiscal year

1985, CHC's out-patient revenue increased 33% over fiscal year 1984, and accounted for 32% of the total hospital revenue.

These developments show continued dedication of effort to provide increasingly sophisticated diagnostic and surgical services without the necessity of overnight hospitalization.

The Community Health Center is classified as being in a rural area for purposes of PPS, while hospitals less than 20 miles away providing less intense service were classified urban. Hospitals in rural areas are paid under PPS at a substantially lower rate than hospitals in urban areas. In 1985, CHC was officially designated a "Rural Referral Center" by the Department of Health and Human Services, in recognition of the fact that its operational characteristics, scope of services, and resulting costs are more similar to those of sophisticated urban hospitals than to those of typical rural community hospitals. This Rural Referral Center designation has eneabled CHC to receive a higher prospective payment rate than that applicable generally to rural hospitals, although the rate remains below the payment rate applicable to urban hospitals.

This hearing addresses the impact of PPS on the stability of rural hospitals and whether access to quality health care in rural communities is being preserved.

Our comments focus on two areas: first, we address problems with Rural Referral Center provisions for Referral Centers with 200 or fewer beds. Second, we address the problems stemming from the urban/rural distinction in prospective payment.

I. RURAL REFERRAL CENTER REGULATIONS

In the original prospective payment legislation, Congress specifically provided thar rural hospitals with 500 or more beds would be classified as "Rural Referral Centers" on the assumption that rural hospitals of that magnitude would be providing more sophisticated services than the typical small rural hospital, and should therefore be reimbursed at a higher rate. The Rural Referral Center payment reimburses the hospital at the urban prospective payment rate adjusted to the rural area's wage index and other factors. Congress amended the legislation in 1984, to provide an opportunity for smaller rural hospitals (i.e., 100 to 400 beds) to demonstrate that they are sources of specialized care and should qualify as referral centers. Congress directed HHS to develop alternative criteria to qualify rural hospitals based on the quality and nature of the operating characteristics of a Rural Referral Center. The types of factors Congress directed HHS to focus on in making this determination include: wages, scope of services, service area and the range of medical specialties. None of these factors is specifically size related.

In response, HHS, through the Health Care Financing Administration (HCFA), promulgated alternative criteria for hospitals to qualify as Rural Referral Centers. To qualify under this alternative method, HCFA has required a hospital to meet two mandatory and one of three optional criteria. The two mandatory criteria are: (1) that the hospital demonstrate its complexity of services by showing a specified minimum case mix index, and (2) that it meet a minimum number of discharges. A "discharge" is counted each time the hospital discharges a patient who was admitted for an in-patient (i.e., overnight) stay. Initially, HCFA required the hospital to show that it either had 6,000 discharges in 1981 or 6,000 discharges for its most recent cost reporting period. Subsequently, HCFA eliminated the option to use

1981 data, and is requiring hospitals to demonstrate 6,000 discharges for their most recent cost reporting period, in order to obtain and maintain Referral Center designation.

The problem with this provision is that many rural hospitals in the 100 to 200 bed size category which were able to demonstrate 6,000 discharges in 1981, can no longer do so. Like all hospitals nationwide, these hospitals have had progressive reductions of in-patient admissions and discharges since the onset of prospective payment. These reductions, which are a direct result of the prospective payment system, are even greater in hospitals which have taken an active role in implementing out-patient surgical procedures, obtaining noninvasive high technology equipment and aggressively pursuing cost containment measures.

Approximately one-fifth of all currently designated Rural Referral Centers are hospitals such as CHC, in the 100 to 200 bed size category, whose discharges have fallen below the 6,000 threshhold and who will lose their Rural Referral Center status if the criteria are not changed. The reasons for the reductions in discharges are consistent among these hospitals. The primary reason for reduction in discharges is the dramatic increase in out-patient surgeries and other procedures which would have formerly required an in-patient stay. These hospitals have experienced a tremendous shift from in-patient to out-patient over the past five years. The Medicare program has mandated some of these changes by requiring that certain procedures; such as, ophthalmic surgery, be performed on an out-patient basis. In order to better serve their communities, hospitals have established skilled nursing facilities and home health agencies which care for patients who formerly would have been cared for in a hospital.

It is important to emphasize that these are not hospitals with case mix problems. These hospitals have no difficulty demonstrating that they perform a broad range of specialty care through a high case mix index. As the hospitals move the less intricate procedures to out-patient care, in-patient care concentrates on the more complex cases. The end result of this is a higher case mix along with a higher cost to the Rural Referral Center, whose in-patient care is progressively being narrowed to only the most resource intensive types of cases, the cost of which is spread out over fewer patients.

CHC is clearly the type of hospital which the legislation for Rural Referral Centers was intended to benefit. They provide needed specialty care on a level more sophisticated than that of many urban hospitals, to patients in the rural areas of our country. They have cooperated with prospective payment and embraced its goals by aggressively promoting out-patient procedures. In so doing their discharges have fallen below the 6,000 threshhold and they will lose their Rural Referral Center designation and the needed funds it provides. Loss of the Rural Referral Center status will have a direct effect on the care our hospitals will be able to provide. We will be required to cut staffing and services, reducing the quality and scope of care in rural communities throughout the nation. Clearly, the 100 to 200 bed high specialty Rural Referral Center is caught in a bind. By doing what Congress has asked us to do, we are virtually sealing our own doom.

Furthermore, there is no rational reason for this to occur. The 6,000 discharges criterion was not required by Congress, and does not quantify any aspect of a Rural Referral Center that Congress envisioned. It is merely a number, established by HCFA based on 1981 experience, which has been carried over through 1986 without regard to the intervening circumstances. In its recent report, the Prospective

Payment Assessment Commission (ProPAC) states that "rural hospitals have experienced a substantially greater decline in total admissions during the period 1983 to the first six months of 1985 than their urban counterparts."

The 6,000 discharges requirement is unrelated to any legislative criterion, and has not been revised despite substantially changed hospitalization practices over the past several years. This is exacerbated by HCFA's practice of excluding from its count certain types of discharges, although the patients are legitimate in-patients receiving care in the hospitals. If the intent of the discharges criterion is to measure the size of the hospital and the quantity of care it provides, then there is no reason to exclude any discharges.

By not considering the changed hospitalization practices which have moved many former in-patient procedures to out-patient, and by refusing to count certain types of legitimate in-patients, HCFA has jeopardized the status of approximately one-fifth of our Rural Referral Centers. In sum, the intended beneficiaries of the Rural Referral Center legislation are being penalized in ways that Congress never intended, and it is incumbent upon Congress to direct the HHS to correct the situation. The seriousness of this problem is further exemplified by the overall urban/rural distinction in prospective payment rates.

II. URBAN/RURAL DISTINCTION.

The problems for Rural Referral Centers are only one aspect of the overall irrationality of the urban/rural distinction in prospective payment. This distinction is apparently based on an assumption that the care provided in rural hospitals is provided at a lower cost than the equivalent care in urban hospitals, an assumption which is simply not true, particularly for those rural hospitals which are Referral Centers.

Lines have been drawn designating certain counties and the hospitals within them as "urban" while contiguous counties are considered "rural" and subject to a substantially lower payment rate. The result of this is that even with the Rural Referral payment, a hospital providing complex specialty care in a rural location receives a lower rate of payment than a community hospital providing fewer services in an urban location, even though that location may be separated by only a few miles from the rural hospital. In the case of CHC and other similar Referral Centers, there is repeated and overwhelming evidence of no basis for this distinction. Rural Referral Center hospitals incurred no lesser costs than urban hospitals for the provision of staff, services, supplies and capital. Indeed, in many instances, the cost to the rural hospital is higher.

1. Staffing. Recruitment and retention of medical personnel and support staff for the Rural Referral Center may be more costly than that for the urban hospital. Rural hospitals have difficulty recruiting specialists away from the city. Frequently we must pay expensive "headhunter" fees, and provide salary and benefits greater than those provided by urban hospitals in order to attract and retain medical specialists. CHC must compete in salary and benefits with large state and veteran's hospitals in Kalamazoo and Battle Creek. The same is true for technical and nursing staff. Although such staff are not generally recruited through the use of headhunters, Referral Centers must compete with urban hospitals for personnel and often must match compensation and benefits. CHC's wage rates for nurses, medical technologists, and other medical personnel are comparable to and in some instances higher than the wage rates applicable in Calhoun County, the adjacent county which is classified as urban. CHC must compete with hospitals in Kalamazoo and Lansing for personnel. The state of Michigan opened two new prisons and a geriatric psychiatric facility in Coldwater. Their wages are identical to State

facilities in urban areas which CHC must compete with for staff. This anomaly was addressed by ProPAC in its recent report that PPS "ignores the problems of 'border' hospitals which must compete with urban hospitals for labor."

2. Services. It is also true that services may be no less costly for rural hospitals than for urban hospitals. Utility rates do not vary from urban to rural areas. The cost of repair personnel to work on technological equipment is no lower, and in fact is higher, because the repair companies are usually city-based.

3. Supplies. Our experience shows that supplies are no less costly for rural hospitals. In fact, urban hospitals which tend to be larger are often able to obtain volume discounts which give them an advantage over rural hospitals. Rural hospitals which are able to obtain volume discounts for themselves by membership in group purchasing organizations pay no less for the supplies than do urban hospitals in the same organization. In fact, rural hospitals will pay even more in these circumstances because of the cost of freight to the rural area.

4. Capital. Interest rates for Rural Referral Centers have been no lower than for urban hospitals. In fact, they may be higher if the rural hospital is perceived as a greater risk due to its small size. Distinctions between urban and rural capital payment rates are unjustified.

In sum, the entire premise for the differential in payment between urban and rural hospitals is flawed. The major expenses of the hospitals are similar and may be greater for rural hospitals such as Rural Referral Centers which provide complex services. The result is an inequitable two-tiered system in which Medicare pays more to a primary care hospital that provides fewer services than to a secondary or tertiary care hospital providing broader and more intensified services, simply because the former is classified an urban hospital and the latter is classified rural.

III. CONCLUSION

In summary, rural hospitals, in particular Rural Referral Centers of 200 or fewer beds, are being seriously threatened by Medicare policies regarding Rural Referral Center designation and differentials in urban and rural payment rates. The access to high quality health care provided by small Rural Referral Centers may soon be substantially cut off because of unreasonable policies.

Thank you for the opportunity to testify. We are continuing to collect data from Rural Referral Centers and will supplement the record with information as it becomes available. We will be pleased to supply the Committee with any further information it may require.

CK

cha California Hospital Association
1023 12th Street   P.O. Box 1100   Sacramento, CA 95805-1100   916/443-7401

May 22, 1986

Honorable David Durenberger
Chairman, Health Subcommittee
Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Durenberger:

Please accept the attached input to the record of the May 9, 1986 hearing on the Medicare Prospective Payment System (PPS) and rural hospitals.

If you have any particular questions about the effect of PPS on California's small and rural hospitals, do not hesitate to call.

Sincerely,

John H. Ferman
Senior Vice President

JHF:bg

cc: C. Duane Dauner
Management Countil
Rural Hospital Advisory Board

INPUT TO THE RECORD OF THE HEALTH SUBCOMMITTEE OF THE SENATE FINANCE COMMITTEE REGARDING THE MEDICARE PROSPECTIVE PAYMENT SYSTEM AND RURAL HOSPITALS

Our purpose is to comment on the following effects of the PPS System on rural hospitals in California:

* Under-payment of costs as a result of statistical fluctuations.
* Cash flow deficiencies.
* Probable restrictions on renovation and modernization as a result of proposed capital costs reimbursement policies.

Further, we will comment on the need for more flexible criteria for participation in the swing bed program.

Under-payment of costs as a result of statistical fluctuations

PPS is a scheme of reimbursement which sets a fixed price for each of the 471 Diagnostic Related Groups (DRGs) based on the historic national average costs per case for that DRG. The system is predicated on the assumption that, although any individual case may require treatment which is considerably more expensive (or considerably less costly) than the DRG price, costs will average out over time to levels comparable to the DRG prices in efficiently managed hospitals. This assumption is likely to break down when a hospital treats few cases within some or all DRGs, and the "law of averages" no longer applies.

Most California rural hospitals have relatively low utilization levels in terms of number of cases. This leads to under-payment of costs, especially in the short run, as well as situations where the hospital may gain revenue on a particular case. While this could even out over the long term, (even with a small number of cases), we are concerned about the ability of many rural hospitals to continue to function in the short term if there is significant under-payment either in a few large cases or the aggregate of smaller cases. Recently, a number of California rural hospitals indicated that under-reimbursement of costs, (which are not concurrently being offset by cases where there are gains in revenue), is a serious problem.

Given the fragile nature of small rural hospitals, and their important role in the health care delivery system, this concern cannot be put aside by the typical bureaucratic comment that "the system will work out over time" - especially when the amount of time needed for the "system" to work cannot be defined.

The problems of under-payment are exacerbated by other factors:

(1) The mix of patients admitted to the acute care hospital are generally sicker than patients admitted prior to the advent of PPS. This leads to a greater intensity of service which incurs greater costs even though the length of stay may now be shorter.

(2) Because of the lack of skilled nursing facilities (SNFs), or the inability of some rural hospitals to qualify for swing beds, patients ready for discharge from acute care - but still needing skilled nursing care - are often difficult to place. Rural physicians tend not to discharge patients as readily when the only alternative is placement in a skilled nursing facility at a great distance from the home community.

Further, rural physicians tend to be aware of a patient's home situation and, therefore, as appropriate, retain the patient in the acute setting if only a few additional days can make the difference between the patient going home or going to a skilled nursing facility in another community. Any increase in the length of stay will increase costs to some degree.

(3) Rural hospitals with a higher portion of their case load falling into certain speciality areas may be penalized because of total lack of volume in all other speciality areas. For example, rural hospitals which serve a number of orthopedic patients will invariably lose significant dollars on those cases. Because of relatively low volumes, losses on orthopedics will not be offset through a broad mix of other DRGs which includes "winners" such as urology and psychiatry, etc.

Recommendation -

Lower outlier thresholds.

Increase the amount of outlier payment (as a percent of the underpayment).

Assure that an appropriate percentage of total outlier payments, for all facilities, flow to rural hospitals.

Cash flow problems

With the recent HCFA mandates to fiscal intermediaries (FIs), there has been a significant increase in the turnaround time for payment of routine claims. For example, one typical rural facility on DDE (Direct Data Entry) has had its turnaround time increase from 3 days to 28 days. This well-managed 33-bed hospital, fortunately, has a good line of credit with its local bank because it has had to borrow (at 10 percent interest) to meet payroll. For hospitals not on DDE, the situation (and turnaround time) is futher compounded.

For small rural hospitals on PIPs (Periodic Interim Payments), there is a different problem. Certain FIs fail to tie PIP payments made to services provided. This often results in the rural hospitals being placed on "withhold" or reduced payments until quarterly adjustments are finalized. This also causes a cash flow problem.

Recommendation -

> *Assure that all routine claims are paid within 15 days of submission.*
>
> *Assure that the PIP program is maintained to smooth out cash flow for hospitals with seasonal fluctuations; relax requirements for participation.*

Probable restrictions on renovation and modernization

In addition to limiting the magnitude of capital payments, the Administration also proposes to link the distribution of Medicare capital dollars to the hospitals Medicare admissions and case mix rather than to its overall pattern of investment. This would be accomplished by adding an amount to the non-labor portion of the Standardized Payment for each case. Such an approach is especially inappropriate for small rural hospitals because under such a scheme, the average facility could never attract (or accumulate) the capital necessary to carry out any significant modernization or renovation.

This is a critical point because most small rural hospitals in California were built over 20 years ago. Using "average asset age" as surrogate for physical age, California small rural hospitals, as a class, are 80 percent older than their small urban counterparts. With few exceptions, California small rural hospitals cannot be in any way characterized as surplus or unneeded facilities which should be phased out. For the most part, these facilities are the "hub of health" in remote areas, not only serving the resident populations but also the tourists from urban settings were access to health care is taken for granted.

Using what appears to be the logic in the Administration's approach to capital payments, it can be deduced that a 50-bed hospital would receive about one half the capital dollars as would a 100-bed hospital -- all things being equal. Carried one step farther, this same "linear logic" implies that to replace, for example, the dietary unit in a 50-bed hospital would cost one half of what it would cost to replace the dietary unit in a 100-bed hospital.

Because of utilization patterns in smaller hospitals, it is unlikely that the 50-bed hospital would receive even half of the capital dollars as the 100-bed hospital but more importantly, this approach to capital payments ignores the concept of "economies of scale" and the realities of costs of construction which meet various life - safety codes. (In California seismic codes have increased construction costs 10 to 14 percent in the past few years. Even hospitals undertaking modernization and renovation - as opposed to new construction - must meet the seismic safety requirements.)

Recommendation -

> *Retain the current system of pass through costs for rural hospitals.*

Need for more flexible criteria for participation in the swing bed program

The criteria for participation in the swing bed program should be expanded to allow hospitals with more than 50 beds to participate. In California we have as many as 20 facilities which are located in rural areas serving rural populations and yet cannot qualify for participation because of the 50 bed size limitation.

For a variety of reasons, the rural health care system often lacks a continuum of care. The swing bed program could be a major factor in alleviating this problem by improving the system link between acute inpatient care and the patient returning home. Such a linkage is critically needed in many rural communities where there is typically a higher proportion of elderly persons.

It is important to note that the swing bed program cannot be construed as a threat to the skilled nursing industry since it is not supplanting any opportunities for that industry to participate. If, in rural areas, the skilled nursing industry can (a) afford to to build facilities; and (b) provide appropriate levels of care, then they can also participate in meeting what is currently an unmet need.

Recommendation: Set maximum bed size at 75.

DAY
KIMBALL
HOSPITAL

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PUTNAM, CONNECTICUT 06260
203 928-6541

CHARLES F. SCHNEIDER, FACHA
Executive Director

May 8, 1986

Betty Scott-Boom
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

RE: "Hearing on Rural Hospitals Under Medicare - .
May 9, 1986"

Dear Ms. Scott-Boom,

We would like to take this opportunity to indicate our concurrence with and support of the testimony to be presented to you by Caylor-Nickel Hospital on May 9, 1986.

The Day Kimball Hospital is a 148-bed 501 (c)(3) charitable entity located in Putnam, CT. The Hospital serves an area of approximately 400 square miles which has been designated by the Federal Government as medically underserved. It has also been granted Sole Community Provider status by HCFA.

Like Caylor-Nickel Hospital we have an extremely high percentage of Board Certified or Board Eligible Specialists and have been aggressively promoting outpatient care as an alternative to inpatient specialization. Our current case mix index is 1.1860 indicating a high degree of complexity of medical services performed.

Initially we had commented to HCFA and to our legislative representatives regarding the inappropriate assumptions which were made in developing the urban/rural distinction in the prospective payment system, which resulted in a reduction of about 20% in the rural rate. Attached is a copy of a letter sent by Congressman Samuel Gejdenson, which we feel accurately expresses the overall irrationality of the urban/rural distinction, which is also expressed in pages 10 through 14 of the Caylor-Nickel testimony. Also, the PPS enabling legislation called for a study and report, by the end of 1985, from H.H.S. addressing the feasibility of eliminating separate urban and rural rates.

Subsequently, on 7/3/84 regulations were published relative to qualification for "Rural Referral Center Status". These regulations allowed hospitals such as Day Kimball and Caylor-Nickel to qualify for an "almost urban" rate (still adjusted for a "rural" wage rate) and allowed HCFA to avoid facing the initial issues raised by the arbitrary urban/rural split.

Although the thrust of the Congressional direction to develop these Rural Referral Center criteria appeared to be related to wages, scope of services, service area and medical specialties, a required number of 6000 discharges was also added by HCFA. This number has been carried forward from 1981, without regard to changing medical practice patterns. A hospital such as Day Kimball which has cooperated with the goals of the prospective payment system and aggressively promoted outpatient services as an alternative to inpatient hospitalization finds itself in danger of losing about 20% of an already inadequate reimbursement amount, by falling below the 6000 discharge figure.

We appreciate your consideration to our concerns as contained in this correspondence and to the more detailed information contained in the testimony of Caylor-Nickel Hospital.

Sincerely yours,

Charles F. Schneider

Charles F. Schneider, FACHA
Executive Director

rfj/cfs/jvl
enc.

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

SAM GEJDENSON
2D DISTRICT
CONNECTICUT

COMMITTEES:
FOREIGN AFFAIRS
INTERIOR

August 28, 1984

Ms. Carolyne Davis, Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: BERC-279-P
P.O. Box 26676
Baltimore, Maryland 21207

Dear Ms. Davis:

I am taking the liberty of writing in regard to the proposed rules issued in the Tuesday, July 3, 1984 Federal Register relating to Hospitals in Areas Redesignated as Rural.

I believe that the arbitrary designation of a hospital as a rural hospital simply because it falls in a county that has been determined to be rural by the Office of Management and Budget is inaccurate and unfair. OMB makes its designation based on the 1980 census data for a particular county -- for Medicare purposes, however, this designation does not take into consideration the special problems due to a county's particular location in relation to "urban" designated areas. It would be more appropriate to designate a hospital as being rural on an individual basis, and not by which county the hospital may be located in.

Two hospitals in my district, Windham Hospital and Day-Kimball Hospital, both of Windham County, have been designated as rural hospitals because of the designation of the county. These hospitals have been faced with an abrupt, and drastic, change in their level of Medicare reimbursement as a result of this designation. In the State of Connecticut, there is no economic support to differentiate these hospitals from other hospitals in the area that have been given an urban classification.

Windham Hospital, for example, is located within one mile of two towns which are part of the Hartford PMSA. If Windham Hospital were located just one mile to the west, they would have been designated as an urban hospital. The hospital draws its patients from urban towns, which represent 35% of the total population for the service area, and a large percentage of Windham's employees come from urban towns. Day-Kimball is in an area that is proximate to Worchester, Massachusetts and Providence Rhode Island, and competes with hospitals in these urban-designated areas for patients and employees. Both hospitals, according to the Connecticut Hospital Association's survey of wages, pay wages in the same range as most of the hospitals in Connecticut.

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Furthermore, costs for non-salary items such as office supplies, medical and surgical supplies, equipment repairs, medical equipment, etc., are another major portion of the total operating costs of these hospitals. They must pay the same prices for these goods and services as those hospitals that have been designated as urban, because they must purchase from the same vendors. In addition, in an effort to contain costs, the hospitals participate in the Connecticut Hospital Association's group purchasing program. Most of Connecticut's hospitals purchase using this program, and all who participate pay the same price.

I am certain that there are other hospitals throughout the United States that have circumstances similar to these two hospitals. I would, therefore, like to urge that HCFA evaluate a hospital's designation on an individual basis, rather than on the designation of the county in which it is located. I simply feel that there are too many additional circumstances involved with a hospital's operations to make such a costly evaluation on such a simplistic basis.

Thank you for your attention to this matter.

Sincerely,

SAM GEJDENSON
Member of Congress

HEARING ON RURAL HOSPITALS UNDER MEDICARE
TESTIMONY OF HALSTEAD HOSPITAL
May 9, 1986

Halstead Hospital, located in Halstead, Kansas, is a Rural Referral Center under the Medicare prospective payment system. Rural Referral Center designation recognizes rural hospitals which provide a broad scope of specialized care, and Medicare pays such hospitals at a higher rate than the standard rural hospital rate, in recognition of the fact that complex services entail higher costs.

Halstead Hospital qualified as a Rural Referral Center in 1984, with the designation taking effect in October of that year. The hospital qualified under Health Care Financing Administration (HCFA) guidelines which stipulated that referral centers must have at least 60 percent or more of their Medicare patients coming from more than 25 miles away, that at least 60 percent of Medicare charges are attributable to those patients, and that more than half of the hospital's Medicare patients are referred to the hospital by either another hospital or a physician not on the hospital's staff. At the time Halstead Hospital qualified, there was no mention of a minimum size or number of inpatients treated annually.

It is our understanding that HCFA is requiring Rural Referral Centers to treat at least 6,000 inpatients annually. Of those hospitals which qualified as Regional Referral Centers initially, nearly 20 percent no longer have annual admissions of 6,000 or more, due to the switch from inpatient treatment to outpatient treatment. This development, we feel, is a direct result of insurance programs and government plans (such as the prospective payment system), which encourage outpatient treatment. Indeed, we in the health care industry are struggling to make adjustments to a more cost-effective manner of treatment, and have adapted many of our previous inpatient procedures to outpatient basis, and are now facing the possibility of being penalized for this accomplishment.

If Congress does not see fit to change this requirement with regard to admissions of 6,000 or more annually, many hospitals will be unjustly penalized and lose their status as Rural Referral Centers. This will amount to an annual loss of $400,000 to $500,000 for Halstead Hospital alone. Such a severe cut in annual income would force drastic cuts in the services available at Halstead Hospital.

Halstead Hospital is a 190-bed acute care hospital located in South Central Kansas, approximately 35 miles northwest of Wichita. The hospital is closely affiliated with the nationally-noted Hertzler Clinic, a multi-specialty physician group. Each year, the Hertzler Clinic sees nearly 50,000 people from all counties in Kansas and nearly every state in the Union.

Halstead Hospital and the Hertzler Clinic have been regarded as the "rural alternative" to metropolitan tertiary care since the 1930's. The two facilities offer specialty care on a level comparable with that found in many metropolitan hospitals, but with a personal touch and in a small town setting of only 2,000 people. To many rural Kansas residents, the presence of these facilities in a small town helps alleviate the worries of travel to a metropolitan area when they are already in a situation rife with stress.

It should be noted that Halstead Hospital does not receive similar compensation to its urban counterparts for similar services. The structure of the prospective pricing system has established urban medical care at a higher rate of reimbursement, even though Halstead Hospital must match the salaries paid in Wichita, frequently has to pay more for supplies and freight, and in general has similar overhead. Hospitals such as Halstead have already been penalized for their rural locations, and, indeed, if Rural Referral Center status were to be revoked, would not be able to offer the same high quality of specialty care as is currently the case.

Halstead Hospital and the Hertzler Clinic have been in the forefront in assuring the continuation of the availability of primary health care in rural locations. The hospital and clinic currently operate clinics in 10 Kansas communities, helping to underwrite the expense of maintaining those practices in remote rural locations. This is a benefit to the primary care physicians, to rural hospitals, and to the residents of western Kansas. The clinic and hospital have also instituted a program of visiting physician consultants, with orthopedic surgeons, psychiatrists, ophthalmologists and cardiologists flying to remote Kansas locations to make specialty services available.

In addition, the hospital and clinic are currently working on the feasibility of establishing a preferred provider organization (PPO), which would provide comprehensive health care at rates much lower than the current market. Halstead Hospital and the Hertzler Clinic can provide nearly all the comprehensive services of the major metropolitan hospitals, but at a much lower cost--a benefit that is directly provided to the government, to insurers, and to private payors. If a facility such as Halstead Hospital ceased to exist, the services provided would be available elsewhere, but in a metropolitan setting and at a cost much higher than is presently the case.

Halstead Hospital had 5,022 discharges in 1985, and 4,535 outpatient procedures and/or treatments were performed. This is in addition to the 50,000 outpatient visits at the Hertzler Clinic.

Halstead Hospital's current case mix index, which is the Medicare formula to measure the complexity of medical services performed in a hospital, is 1.2305. This is certainly comparable to the metropolitan hospitals in this region, proving that Halstead Hospital is performing specialized medicine on a basis equal with any metropolitan hospital in the area.

It cannot be stressed too strongly that the present prospective payment system is unequitable in its treatment of hospitals. Halstead Hospital, for example, is located six miles north of the Sedgwick County line, thus missing by six miles the ability to qualify for the payment structure of the metropolitan statistical area (MSA). Those six miles have been responsible for the loss of over $1 million annually in reimbursement to Halstead Hospital, which is how much higher urban hospitals are compensated than rural hospitals are. To now face the loss of a half-million dollars, which would be the result of a loss of Rural Referral Center status, is almost staggering--especially when such loss would be caused as a result of policies pushing toward higher outpatient utilization which the federal government has strongly supported. All hospitals have lower inpatient utilization as a result of these, and other market conditions. Many hospitals are struggling to come up with new and innovative ways of providing high quality health care at lower costs. And many hospitals, such as Halstead, are engaged in an active program to salvage the availability of primary care in rural settings, and to provide the option of tertiary care in a rural setting. It is vitally important that all of these options be maintained--not only for the benefit of Halstead Hospital and the patients it serves, but for the good of all rural Kansas residents.

May 18, 1986

Betty-Scott-Boom
Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

"HEARING ON RURAL HOSPITALS UNDER MEDICARE-MAY 9, 1986"

IT IS IMPERATIVE THAT REGULATIONS FOR PATIENT ADMISSIONS IMPOSED ON RURAL REFERRAL CENTERS BE MODIFIED AND MINIMUM COUNT BE LOWERED. ALPENA GENERAL HOSPITAL IS IN JEOPARDY OF LOSING THEIR REFERRAL CENTER STATUS BECAUSE OF THIS HIGH IMPATIENT COUNT.

THIS INSTITUTION IS A VERY VITAL PART OF THIS COMMUNITY AND GEOGRAPHICAL AREA IT SERVICES, AND IS NEEDED TO CONTINUE THE GROWTH OF THE AREA. THREE COUNTIES WITH SEVERAL SMALL COMMUNITIES DEPEND SOLEY ON THIS HOSPITAL FOR THEIR HEALTH CARE NEEDS. WE ALSO HAVE AN ABOVE AVERAGE POPULATION OF SENIOR CITIZENS. TO LOSE REFERRAL STATUS WOULD BE ECONOMICALLY DAMAGING TO ALPENA AND PLUNGE THIS INTSTITUTION INTO EVENTUAL BANKRUPTCY.

I FEEL IT IS IN THE BEST INTERESTS FOR ALL CONCERNED THAT ADMISSIONS COUNT BE LOWERED. ALPENA HAS MADE A BIG INVESTMENT AND COMMITMENT TO THIS HOSPITAL AND DESERVES FOR IT TO CONTINUE. BECAUSE OF LOCATION AND TRAVEL DISTANCE TO ANY OTHER MAJOR HOSPITALS, WE FEEL VERY STRONGLY THAT THE MINIMUM ADMISSION REQUIREMENTS BE LOWERED TO ENABLE TO MAINTAIN OUR REGIONAL REFFERAL CENTER STATUS.

SINCERELY,

Shirley & Guy Houston

SHIRLEY AND GUY HOUSTON

1261 DOW DRIVE
ALPENA, MICHIGAN 49707

CC: U.S. SENATOR DONALD W. RIEGLE, JR.
U.S. SENATOR CARL LEVIN
U.S. REPRESENTATIVE ROBERT W. DAVIS
STATE SENATOR CONNIE BINSFELD
STATE REPRESENTATIVE JOHN PRIDNIA
ALPENA GENERAL HOSPITAL

Hearing on Rural Hospitals Under Medicare-May 9, 1986.

In May of 1944 my first trip to Alpena General Hospital--Emergency surgery saved my life and that of my unborn son. He was born in November of 1944.

In the ensuing years "Our Hospital" has been there for my husband and myself several times when needed.

We live 27 miles from the city limits of Alpena. Hundreds of other people from small surrounding towns also depend on Alpena General Hospital.

Small towns are not immune to high cost of health care, it is nationwide.

Alpena General Hospital serves the public with surgery and home the same day to help cut cost to patient and insurance carriers. They should be complimented not penalized for cutting costs. The count of all these people should be as one with the inpatient for a total count of those served.

My husband and I are both volunteers at Alpena General Hospital. It is worth the commuting for us to serve at the hospital.

PLEASE leave Alpena General Hospital as a Rural Referal Center.

PLEASE DO NOT TAKE AWAY OUR LIFE LINE.

Sincerely,

Helen (Mrs. Sanford) Josephson

3030 Richland Drive

Lincoln, Michigan 48742

HEARING ON RURAL HOSPITALS UNDER MEDICARE - MAY 9, 1986
BY JACKSON COUNTY MEMORIAL HOSPITAL, ALTUS, OKLAHOMA

Jackson County Memorial Hospital of Altus, Oklahoma is both a Rural Referral Center and a Sole Community Provider under the Medicare Prospective Payment System.

As a Sole Community Provider, Jackson County Memorial Hospital is the only acute care hospital in Jackson County and captures 90% of the Jackson County residents hospitalized last year.

Operating 112 acute and critical care beds plus a 25 bed Skilled Nursing Facility, Jackson County Memorial Hospital also serves as a "Rural Referral Center" for Southwest Oklahoma and Northwest Texas. Over 36% of the patients hospitalized in JCMH are residents of the surrounding counties in Oklahoma and Texas. Most of these patients are referred for specialized care including Orthopedics, Ophthalmology, Internal Medicine, General, Peripheral & Vascular Surgery, Obstetrics and Gynecology, Urology, Gastroenterology, and other speciality care. Over 60% of the physician members of the active medical staff are specialists and the hospital's case mix of specialty care is significant. For example, in specialized Orthopedic care, Jackson County Memorial Hospital performs more major joint replacements procedure than any other hospital in the state.

In support of these specialized services the hospital has a new facility with state-of-the-art diagnostic equipment. Our outpatient surgery volume has increased over 63% this year, our outpatient referred volume for diagnostic services has overall increased more than 80% this year with service increases in outpatient activity including 132% in outpatient Laboratory, 83% in outpatient Electrocardiogram, 111% in outpatient Pathology, 211% in outpatient Ultrasound, 65% in outpatient Respiratory Therapy, 42% in outpatient Physical Therapy, 112% in outpatient Stress Testing, and new Home Care Services with a monthly volume of over 700 visits. All these volume increases in outpatients are the result of an increase in diagnostic and surgical services without the necessity of overnight hospitalization.

Effective July 1, 1985 Jackson County Memorial Hospital was designated by the Department of Health and Human Services as a "Rural Referral Center". As a result, Jackson County Memorial Hospital has received a significantly higher prospective payment rate than is given generally to rural hospitals although the rate does remain below urban hospitals for the same services.

Congressional intent was to base qualifying criteria on the quality and nature of the hospital as a "Rural Referral Center". The quality and nature of the operating characteristics of Jackson County Memorial Hospital as a Rural Referral Center is unchanged from last year. However, there has been a shift in inpatient admissions due to the greater utilization of outpatient surgery procedures and other diagnostic technology which does not necessitate overnight admission! Within the last year Jackson County Memorial Hospital has established a Skilled Nursing Facility and an active Home Care Agency for care of patients.As previously mentioned, we have experienced a tremendous shift from inpatient to outpatient during the last year. As a result of all these factors, Jackson County Memorial Hospital's number of discharges has decreased from the 6,000 minimum criteria. All of our speciality characteristics have remained the same.

Loss of Jackson County Memorial Hospital's Rural Referral Center status will have a direct effect on the care our hospital will be financially able to provide in Southwest Oklahoma and Northwest Texas.

I sincerely request consideration to lowering the minimum number of discharges criteria for determination of Rural Referral Center status. The character and scope of services provided in Jackson County Memorial Hospital remains the same. The cost of such services is no less than those same services provided in urban areas. The cost of staffing and equipping is the same or more than the urban areas. The quality of our services are no less than the quality provided in the urban areas.

The cost of supplies and maintenance services is usually greater than our urban counterparts. In addition, the higher cost of capital and the unavailability of philanthropy are two other disadvantages of rural hospitals compared to the urban centers. Consequently, the inequitabilities of a two-tiered payment system for the same or equivalent services is truly unjustified.

JD Adair

Jerry D. Adair
Chief Executive Officer
Jackson County Memorial Hospital
May 6, 1986

STATEMENT OF THE MONTANA HOSPITAL ASSOCIATION
BEFORE THE
SENATE FINANCE COMMITTEE
ON
THE IMPACT OF THE PROSPECTIVE PAYMENT SYSTEM ON SMALL AND RURAL HOSPITALS
MAY 9, 1986

America's small and rural hospitals are literally and figuratively at a crossroad. These hospitals stand in communities that serve rural America as local and regional trading and service centers. The hospital is the focal point of rural health services, created by the community it serves through the donation of money, energy and talent. After World War II the United States experienced a boom in new hospital construction, spurred on, in part, by the Hill Burton program. Many small and rural hospitals were built during this period, bringing the benefits of modern medical technology closer to an underserved population. The boom is over. Small and rural hospitals, as a group, are beginning a cycle of decline. They stand today at a crossroad of another sort. Down one road, the pattern of decline will continue. Small and rural hospitals will close. According to the American Hospital Association, more than 70 percent of the 61 hospitals that closed in 1985 had fewer than 100 beds. Down the other road, there is hope. There is no guarantee against closure, but down the road is the promise that through thoughtful strategic planning and sound financial management chances of survival are enhanced.

On behalf of the sixty short stay non-federal, non-state owned hospitals in Montana, fifty of which are under one-hundred beds in size, the Montana Hospital Association welcomes the opportunity to present this statement to the Senate Finance Committee. We would like to explain how small and rural hospitals came to this crossroad and the meaning and consequence of the two possible paths they can follow. To illustrate our discussion we will use the utilization and financial information of the thirty Montana hospitals that have fewer than thirty beds.

The adoption of the prospective payment system (PPS) in October 1983 was a landmark event in the history of American hospitals. Dramatic changes in utilization and finance can be marked from that date. For example,in 1981 the average length of stay at these sample hospitals was 4.54 days. There was no change in length of stay between 1981 and 1982. In 1983, the last year before PPS, average length of stay declined to 4.48 days, a modest 1.4 percent decrease. In 1984, the first year of PPS, the average length of stay plummeted to 4.05 days, a one year drop of 9.7 percent. It was originally felt that this drop represented a medical practice adjustment to PPS. The primary incentive of PPS is for hospitals to treat patients more efficiently. With such a low length of stay after the first PPS year it was assumed that all of the practice inefficiency had been wrung out of hospital utilization. (The national average length of stay in 1984 was 7.3 days.) However, in 1985 length of stay fell again, this time below 4 days to 3.88 days. In two years, the average length of stay has dropped 13.4 percent. Although length of stay has exhibited a downward trend in recent years, it has been rapidly accelerated by PPS.

The other side of the utilization equation is admissions per year. In 1981 total admissions were 14,460; the following year, 1982, they climbed to 14,909. In 1983 they returned to approximately 1981 levels or 14,538. In the first year of PPS, 1984, they fell sharply to 13,716, a reduction of 5.7 percent. Once again it was believed that the decline represented a one-time practice adjustment to PPS and peer review organization criteria, but again that assumption was proved wrong. In 1985, admissions dropped to 11,687, a one-year decline of 14.8 percent. In the two years of the PPS system, admissions in the sample hospitals have fallen by 19.6 percent. Certainly, outmigration of patients from rural hospitals to secondary and tertiary facilities is a trend that has been occurring in recent years, but the rapid decline in the last two years in hospital admissions can largely be accounted for by the adoption of PPS.

A shorter length of stay and reduced admissions conspire to produce the third measure of utilization, inpatient days. Over the course of four years, the sample hospitals lost approximately one-third of their patient days! In 1982 they provided 67,749 days of care; in 1983, 65,130 days of care were provided, or 3.9 percent fewer than the previous year. In the first year of PPS, patient days declined by 14.8 percent to 55,497 days of care. In 1985, they dropped by another 18.2 percent to 45,375. The two year PPS effect of shortened lengths of stays and fewer admissions resulted in a reduction in patient days of 30.3 percent.

Declining utilization has its effect on hospital finance. Hospital expenses are unable to decline in direct proportion to reductions in utilization. Small hospitals must contend with fixed costs. A standard definition of fixed costs is difficult to obtain in the hospital industry. There is widespread agreement on expense elements such as depreciation, interest, insurance, and rentals. There is less agreement on the amount of expense in categories such as salaries, benefits, supplies and utilities that can be considered fixed. Some estimate that as much as 75 to 80 percent of all hospital expense exhibits a fixed cost behavior. Certainly in small hospitals the percentage is somewhat greater. When a hospital employs only one pharmacist, it is difficult to reduce his time; when only one night RN and her weekend coverage are on the payroll, it is difficult to implement creative staffing strategies. Smaller hospitals have less flexibilty than larger hospitals. Many of their fixed expenses are the result of meeting licensure and Medicare participation regulations.

All expenses, whether fixed or variable, are increasing in terms of unit cost. In 1984, despite a decline of 14.8 percent in patient days, total expenses increased by 4.3 percent. In the face of an 18.2 percent patient day decline in 1985, total expenses dropped by only 1.6 percent. Because expense cannot decline in proportion to utilization, it necessarily follows that the cost per unit of service, cost per case, must rise. First there are fewer units over which to spread fixed costs and second the price of variable costs continues to rise as suppliers demand more for goods and services. Between 1984 and

1985 the average cost per case increased by 10.2 percent. This level of increase was made possible only by across the board cuts in all expense categories. There is very little left to cut.

The first PPS year, 1984, was a bad year for small and rural hospitals in Montana. The second PPS year was even worse. In 1985 total inpatient revenue fell for the second straight year to the lowest level since 1981. In 1984, the study hospitals posted a loss from operations of $2,209,183. In 1985, the loss increased to $2,232,758 on net patient revenue of $21,096,829.

Many of these small and rural hospitals benefit from non-operating revenue. Non-operating revenue comes from two major sources. First there is government appropriations from counties and taxing districts, then there is interest income on investments and donations. In 1984, tax-based non-operating revenue equaled $1,148,272. In 1985, reacting to the plight of small and rural hospitals, that figure increased a generous 53.8 percent to $1,765,949. In 1984, other non-operating revenue equaled $2,127,280. In 1985 it fell by 63 percent to $787,523. Non-operating revenue fell because interest rates were lower in 1985 than 1984. The sample hospitals also had less money to invest in 1985 as the permanent investment in larger accounts receivable took away the opportunity to invest in interest bearing accounts, and as hospitals spent their reserves on operations. In 1984, non-operating revenue offset the loss from operations to allow a $1,066,369 surplus for the thirty hospitals. In 1985, non-operating revenue also offset the loss from operations, but the loss was greater and the non-operating revenue was less than in 1984. In 1985, the sample hospitals showed a surplus of $320,714, or an average of less than $11,000 per hospital.

These hospitals are clearly on the edge. They have taken the steps that can be taken. They reduced staff; they eliminated waste; they deferred discretionary expenses. Slower payments from Medicare due to billing complexity and programmed slow-downs threatens solvency and credit worthiness. The sample hospitals had an average payment period of 86.75 days in 1985. This is an extremely long time, when one considers that over one-half of a hospital's expense is payroll and it is paid every two weeks. (The national median average payment period in 1984 was 53.25 days.) How long is it before suppliers refuse to sell goods to these hospitals because they do not pay promptly? Cash flow is a major problem.

Thirty communities across Montana depend on these hospitals. From Ekalaka to Libby, from Plentywood to Dillon these small hospitals provide needed services. Despite their number, in the aggregate they are still small. The total operating revenue of the thirty constitutes about fifty percent of the operating revenue of one of the state's larger hospitals (250 bed range).

PPS is a risk shifting experiment. Small and rural hospitals stand to lose greatly under the program. Despite flaws such as the rural/urban payment differential and the area wage index that can create a 30 percent or greater payment differential between hospitals for the same DRG, the major problem with PPS for small and rural hospitals is its basic premise. Prospective payment on a per-case system is an inappropriate payment mechanism for small and rural hospitals. It does not adequately address problems of declining admissions and case-mix changes. The Montana Hospital Association would instead favor a return to cost reimbursement for small and rural hospitals. Cost-based reimbursement recognizes changes in cost related to case mix, admission declines and modifications in community demand. These hospitals participated in the PPS experiment. For them, it did not succeed. The probable consequence of failure is closure. The result will be that many people in rural communities do not have access to needed health services.

Does a continuation of PPS save the Medicare system money? First, there is a question of materiality. These thirty sample hospitals in the aggregate not equal in cost or revenue one hospital of national average size. Second, if these hospitals close, much of the care will be transferred to rural referral centers and urban hospitals which are paid at a richer PPS rate. In other words, the same laundry list of DRGs will cost approximately 30 percent more. Third, due to travel problems nascent medical conditions will likely be postponed until they become acute, increasing the intensity and cost of medical intervention.

So here we stand at the crossroad. We can continue down the PPS road. If we can predict the future based upon the past, we will experience continued utilization declines, slowed claims processing and inadequate payments. Not too far down the road, we can predict many small and rural hospitals closing.

We, as a nation, have another choice. We can agree that PPS is not appropriate for small and rural facilities and return to cost-based reimbursement. This course guarantees nothing. Small and rural hospitals must still contend with the other problems of rural America - physician recruitment, economics and demographics. The return to cost-based reimbursement merely establishes a level playing field upon which small and rural hospitals can carry out their patient care missions.

HEARING ON RURAL HOSPITALS UNDER MEDICARE - MAY 9, 1986

WRITTEN COMMENTS OF RUTHERFORD HOSPITAL, INC.

Before The Senate Finance Committee

Subcommittee on Health

We greatly appreciate the opportunity to inform the Committee of the experience of Rutherford Hospital under the Medicare Prospective Payment System (PPS) and to support the testimony of Caylor-Nickel Hospital, pointing out the remarkable similarities between our hospitals.

Rutherford Hospital is 165 bed, 501(c)(3) charitable entity located in Rutherfordton, Rutherford County, North Carolina and is the only acute care hospital in Rutherford County. We offer a broad range of services and currently have a 30 physician multi-specialty staff. Rutherfordton is one hour or more driving time from the nearest metropolitan areas of Charlotte and Asheville in North Carolina, and Spartanburg in South Carolina and is a major regional provider of health care services. Our active, full time medical staff represents thirteen separate specialties and subspecialties, the majority of which are other than General Family Practitioners, the most common community hospital specialty. Over 90% of the staff is board certified or eligible in their recognized specialty. Our current case mix index, the Medicare formula to measure the complexity of medical services performed, is 1.1332 which greatly exceeds the median urban index for our region and indicates that Rutherford Hospital is performing more specialized medicine than most urban hospitals in the Southeastern United States.

Rutherford Hospital has been in the forefront of institutions taking an active role in reducing health care costs to the consumer. We are in the process of establishing a preferred provider organization through continuing cooperation with local industry, many of which are self-insured. We conduct utilization review for patients insured through forty eight major employers, including Broyhill Furniture, Burlington Industries, Blue Cross and Blue Shield of North Carolina, AT&T, and North Carolina State Employees, among others. These review requirements are stringent, encompassing pre-admission certification, concurrent review, second opinion and other vehicles to deter unnecessary hospitalization.

The similarities between Rutherford Hospital and Caylor Nickel continue. We, too, have increased our utilization of noninvasive, high technology diagnostics such as CAT Scanners, real time ultrasound and fiberoptic equipment to help reduce the need for hospitalization and invasive surgery. Our same day surgery program has exceeded annual projections each year since its establishment in 1984. We served an average of 56 patients per month through the program in fiscal year 1984, 69 patients per month in fiscal year 1985 and project to serve 80 patients per month in fiscal year 1986. This represents a 43% increase in outpatient surgery. In the past three years, our inpatient surgical cases have dropped from 91% of total cases to around 75%

of total cases. Rutherford Hospital currently serves over 40,000 outpatients, an increase of 6,000 over one year ago. These developments reflect our dedication to provide increasingly sophisticated diagnostic and surgical services while decreasing the necessity for overnight hospitalization.

Hospitals in rural areas are paid under PPS at a substantially lower rate than urban hospitals. In 1984, Rutherford Hospital was officially designated as a "Rural Referral Center" by the Department of Health and Human Services in recognition of the fact that its operational characteristics, scope of services and resulting costs are more similar to those of sophisticated urban hospitals than to those of typical rural community hospitals. This rural referral center designation has enabled Rutherford Hospital to receive a higher prospective payment rate than that generally applicable to rural hospitals, although the rate remains below the payment rate applicable to urban hospitals.

As testified by Caylor-Nickel, "This hearing addresses the impact of PPS on the stability of rural hospitals and whether access to quality health care in rural communities is being preserved." We support Caylor-Nickel's contention on experiences of other rural referral center hospitals and offer ourselves as only one example which very nearly mirrors the Caylor-Nickel situation. In conclusion, Rutherford Hospital is being seriously threatened by Medicare policies regarding rural referral center designation and differentials in urban and rural payment rates. The access to high quality care provided by small rural referral centers may soon be substantially cut off because of unreasonable policies.

Thank you for the opportunity to go on record. We strongly support the effort of Caylor-Nickel hospital and would be pleased to supply your committee with any further information it might require.

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SOUTHWESTERN
VERMONT
MEDICAL
CENTER

Robert D. Stout, F.A.C.H.A.
President

100 Hospital Drive East, Bennington, VT 05201, (802)-442-6361

May 16, 1986

Betty Scott-Boom
Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

Re: Senate Finance Committee Hearing on Rural Hospitals
Under Medicare - May 9, 1986

Gentlemen:

The Southwestern Vermont Medical Center of Bennington, Vermont would like to support the testimony given on May 9, 1986 by representatives of the Caylor-Nickel Hospital in Bluffton, Indiana.

The Southwestern Vermont Medical Center was designated a Rural Referral Center because it provides a very high level of care even though it is located in a rural setting. This comes about because of a medical staff educated to the highest level of medicine which makes it possible for them to render care of medical center quality in a rural setting. Our hospital offers a full range of services in obstetrics, gynecology, general and vascular surgery, pediatrics, urology, otolaryngology, ophthalmology, and internal medicine, including pulmonary diseases, oncology, gastroenterology, dermatology and neurology, and highly qualified physicians doing emergency medicine. Seventy-six percent of our medical staff are certified in their respective fields of specialization.

When DRGs began, our hospital qualified as a Rural Referral Center because of the complexity of patients we are caring for and also because we had more than 6,000 admissions. The quality of our staff and care has not changed, but the number of inpatient admissions has dropped remarkedly. This drop came about because of a medical staff and a hospital that was seeking more effective and less expensive ways to provide care to our patients. A very active and successful same day surgery program was introduced but this reduced our admissions by approximately 1,000 each year. This change alone has brought our annual admissions below the 6,000 level and this will make us ineligible to continue as a Rural Referral Center unless the 6,000 rule is changed.

We feel this is very unfortunate because we are doing a better job than ever before providing more care at proportionately less cost. However, we continue to face the same disparity that existed prior to the recognition of the Rural Referral Center status.

We strongly support the testimony of the Caylor-Nickel Hospital in its endeavor to reduce the inpatient admission and discharge requirements or to abolish them altogether in making the determination as to who qualifies for Rural Referral Centers.

Thank you very much for the opportunity to place this in the record on the hearing on rural hospitals under Medicare.

Sincerely,

Robert D. stout
President

RDS/t

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SUMMARY OF COMMENTS AND CONCERNS OF SAINT MICHAEL'S HOSPITAL

Presented to the Senate Finance Committee
Subcommittee on Health
May 16, 1986

Saint Michael's Hospital is a 181 bed, 501 (c)(3) charitable entity located in Stevens Point, Portage County, Wisconsin. Saint Michael's Hospital is the only health care institution located within Portage County, Wisconsin and serves a population in excess of 65,000 residents within the county as its primary service area. The enclosed map, labeled Attachment A, shows the location of Saint Michael's Hospital and Stevens Point in relationship to a urban designated area (Wausau, Wisconsin) located 35 highway miles to the north via a four-lane federal highway. The primary service area of Wausau is in Marathon County, Wisconsin; the southern county line is 15 miles to the north of the city of Stevens Point.

On October 1, 1984 the Department of HHS did recognize that Saint Michael's Hospital was not a typical rural hospital and classified Saint Michael's Hospital as a Rural Referral Center because: Saint Michael's is located in a rural area, the hospital's 1981 case mix index as published in the 1981 Federal Register was 1.0937, **our case mix index as of March 31, 1986 is 1.2299**, (case mix index is defined as HHS's methodology used in measuring the complexity of the medical services performed in a hospital), the number of discharges for our fiscal year ending September 30, 1983 was 6309 and 88 percent of the hospital's active medical staff are specialists.

Saint Michael's has greatly increased its utilization of high technology diagnostics, such as CAT scanner, updated mammography diagnostic testing, stationary and mobile non-invasive vascular lab equipment with a satellite in the city of Wisconsin Rapids, ultrasound, nuclear medicine and high tech equipment used in the screening for osteoporosis. The goal of using this technology is to reduce the need for hospitalization and invasive surgery. Further proof of Saint Michael's as a progressive leader in efforts of cost containment and foreseeing the inpatient/outpatient shift is our ambulatory surgery department, which was opened in 1976. Volume within the department has exceeded our projections each year, and currently, 2,550 or 90 percent of the surgeries performed at Saint Michael's are performed on an outpatient basis. In FY1985 Saint Michael's tested and served 66,000 outpatients, a 19 percent increase over FY1983, with a continued 5-10 percent growth being projected. Conclusion: The above developments show Saint Michael's continued efforts to provide ever increasingly sophisticated diagnostic and surgical services without the necessity of overnight hospitaliztion.

Saint Michael's placement in Group 9, the second highest rated peer group of Wisconsin hospitals under the Wisconsin Rate-Setting Commission, indicates the wide range of special services and intensity of care being offered by the hospital. Of the 15 Wisconsin hospitals in Peer Group 9, Saint Michael's is the ONLY hospital with a RURAL status, yet finds itself in direct competition with one of the URBAN classified hospitals (Wausau) in recruitment and retention of medical personnel and support staff. We also find competition for nursing and technical staff, those qualified people that are a necessity in providing the many high technology programs being offered by Saint Michael's.

With the above statements providing a background on Saint Michael's, my summary comments focus on two areas: (1) the problems with rural referral center criteria for those referral centers with 200 or fewer beds and (2) the problems of the urban/rural distinction under the prospective payment system.

Rural Referral Center Criteria

Although federal law does not require Rural Referral Centers to be of a particular size, HCFA has required these referral centers to treat at least 6,000 inpatients on an annual basis. Herein lies the problem for those rural hospitals in the 100-200 bed size category. While these hospitals could demonstrate 6,000 discharges in 1981, these hospitals, like all hospitals nationwide, have had progressive reductions of inpatient discharges since the beginning of PPS (see Attachment B). These reductions are even greater in those referral centers like Saint Michael's which have taken an active leadership role in implementing outpatient surgical procedures (see Attachment B), obtaining and expanding non-invasive high technology equipment and pursuing measures in cost containment. The current regulations make no provision for the shift of patients who are now appropriately being treated on an outpatient basis. If Congress does not address the arbitrary 6,000-discharge threshold, the 100-200 bed referral centers will lose their rural referral center designation and the needed funds it provides. With the loss of this necessary funding, services and staffing will be cut, reducing the quality and scope of care in rural communities, not only in Wisconsin but throughout the nation.

Urban/Rural Distinction

Current regulations relating to reimbursement of health care providers are based simply on the faulty premise that health care is less costly in rural

America than in its urban counterpart. This is a particularly misleading assumption for those rural hospitals which are Rural Referral Centers.

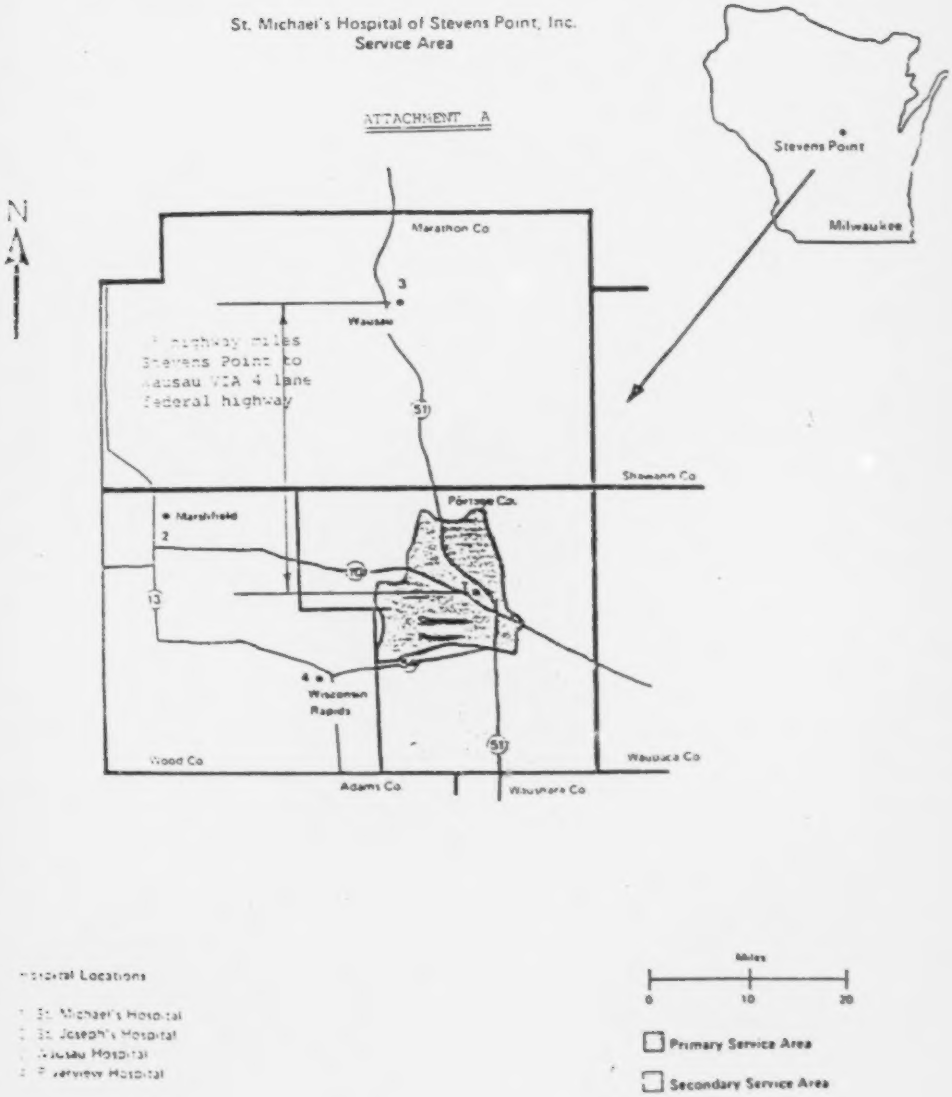
Contained within these regulations are lines designating certain counties and the hospitals within them as URBAN while connecting or "borderline" counties and their hospitals are classified RURAL and therefore subject to a substantially lower rate of reimbursement. Result: Given even a rural referral reimbursement rate, a hospital providing a variety of complex speciality care in a RURAL location receives a lower rate of reimbursement than a hospital providing the same or FEWER services in an URBAN location even though the hospitals are only a few miles apart. Costs to these Rural Referral Centers in the areas of staff, services, supplies and capital acquisition are no less than those of an urban hospital and may, in many instances, be greater.

In summary, the current reimbursement system is indeed inequitable because it reimburses those primary hospitals providing fewer services than a secondary or tertiary hospital providing more complex and intensified services simply because one is classified urban and one is classified rural.

Thank you for the opportunity to submit this data.

St. Michael's Hospital of Stevens Point, Inc.
Service Area

ATTACHMENT A



SAINT MICHAEL'S HOSPITAL

A MEMBER OF MINISTRY CORPORATION
SISTERS OF THE SORROWFUL MOTHER

PR. #52-0002

Attachment B

	For Fiscal Year Ending 9-30-					
	'82	'83	'84	'85	'86*	'87**
Patient days	38704	37719	34103	30885	27220	26280
Discharges	6407	6309	6039	5725	5175	4905
L.O.S.	6.04	5.98	5.65	5.40	5.26	5.25
Amb. Surg. proced.	1484	1553	1763	2203	2550	2700
As % of total surg.	48.9%	55.3%	59.4%	77.0%	90.0%	90.0%
Outpatients seen	52887	55592	61165	65919	67350	69750

*7 months actual, 5 months projected.
**Budget year.

Case mix index as published in September '82 Federal Register	1.0923
Current case mix index, year to date as of 3-31-86	1.2299

900 ILLINOIS AVENUE
STEVENS POINT, WISCONSIN 54481
715 346-5000

Valley View Hospital

PHILIP H. FISHER
PRESIDENT

"HEARING ON RURAL HOSPITALS UNDER MEDICARE"

MAY 9, 1986

I would like to have the following become part of the official record with respect to the May 9, 1986, "Hearing on Rural Hospitals Under Medicare". Thank you.

This brief paper deals with the issue of nine (9) rural Oklahoma Regional Medical Centers maintaining their status as Rural Referral Centers as determined by the Medicare Prospective Payment System. They are: Jane Phillips Episcopal Memorial Medical Center, Bartlesville; Stillwater Medical Center, Stillwater; St. Joseph Regional Medical Center of Northern Oklahoma, Ponca City; Muskogee Regional Medical Center, Muskogee; Jackson County Memorial Hospital, Altus; Grady Memorial Hospital, Chickasha; McAlester Regional Hospital, McAlester; Memorial Hospital of Southern Oklahoma, Ardmore; and Valley View Hospital, Ada.

Each "Center" received their determination because of offering a broad range of specialized health care services, which results from each having specialized medical staffs and higher costs associated with providing advanced levels of patient care. Each hospital actively pursues out-patient services: One-Day Surgery Centers, Home Health Care Services, Hospice Services associated with three of these hospitals, etc., and a commitment to control costs.

1300 EAST 6TH ST. / ADA, OKLAHOMA 74820 / 405-332-2323

Page Two.

Admissions to seven (7) of these hospitals have declined significantly under the Medicare Prospective Payment System (the other two will be at risk in fiscal year 1986-87). This decline threatens our Rural Referral Determination Status.

Should we lose this determination, revenues would fall on the average of $600,000.00 per hospital.

This will NOT save dollars! This will cause price increases. This will cause job lay-offs. This will cause out-patient services to be limited. This will cause our patients to be without needed cost effective services. Plus, our ability to recruit medical specialists will be greatly compromised.

The requirement of maintaining 6,000 patient discharges annually simply should be dropped. This number has no meaning in determining the impact and importance of these hospitals in terms of providing health care to the Medicare patient in a rural community.

Please do everything possibile to allow us to maintain our Rural Referral Status. We are truly the major focal point for health care services to the evergrowing Medicare population in rural Oklahoma.

Page Three.

Thank you for this opportunity to communicate with you.

Sincerely,

Philip H. Fisher

Philip H. Fisher
President
Valley View Hospital
Chairman
Oklahoma Hospital Association

PHF/dg